

9041

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL or and give nearest town) Towson LENGTH OF STAY (in this place) 19 yrs, 6 mo, 28 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard and Enoch Pratt Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Kentucky COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) Louisville
 STREET ADDRESS (If rural give location) 1433 Third St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CarrieHartingAbell

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Sept.1519 56

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

FemaleWhiteWidowDec 6, 187679 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Lexington, Kentucky

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

William Harting

14. MOTHER'S MAIDEN NAME:

Jane Hillenmeyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

-

17. INFORMANT & ADDRESS:

Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X
Immediate cause(a) Broncho pneumonia
DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) DUE TO

(c)

Interval Between Onset And Death

3 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Schizophrenia, Paranoid Type20 yr +

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 17, 1937, to Sept. 15, 1956, that I last saw the deceased alive on Sept. 14, 1956, and that death occurred at 2:35 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. E. Elgin M.D.THE SHEPPARD & ENOCH PRATT HOSPITALTowson, Md9/15/56

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF 9/16/56

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

SEP 16 1956Wm. J. LicknerWm. J. Lickner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The course of age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09015

9042 CERTIFICATE OF DEATH

Item 8 Film G205 10-11-56 et

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Catonsville Md.		MARYLAND		STATE Md.		Ann Arundel COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville Md.		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gibson Island 02X.2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Waynes Convalescent Home				STREET ADDRESS (If rural give location) Boulevard Park, Ann Arundel Co, Md.			
3. NAME OF DECEASED: (First) (Middle) (Last) ***** Clara C. Albert				4. DATE OF DEATH: (Month) (Day) (Year) Sept. 30 1956 19			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: July 12, 1886	9. AGE last birthday: 70 yrs. 76 Months 76 Days 76 Hours 76 Min.		10. AGE last birthday: If UNDER 1 YEAR If UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): none				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore Md.	
13. FATHER'S NAME: -- Freeze				14. MOTHER'S MAIDEN NAME: Elizabeth--			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) --				16. SOCIAL SECURITY No.: 212-05-9271		17. INFORMANT & ADDRESS: Route 1, Box 342 Joseph. Albert, Boulevard Park Ann Arundel Co. Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) 196X Degenerative Heart Disease							
Antecedent causes (s) (b) Carcinoma Jaw left. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. Obstruction Intestinal Partial Chronic							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 1954				19b. MAJOR FINDINGS OF OPERATION: Carcinoma Jaw left			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 55 , to Sept , 19 56 , that I last saw the deceased alive on 9/25/56 , and that death occurred at 6:55 AM , from the causes and on the date stated above.							
SIGNATURE W. E. G. G. M.D.				ADDRESS Catonsville 28 md		DATE SIGNED 9/30/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Oct. 3/56		NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		LOCATION (City, town, or county) (State) Baltimore Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct 1, 1956		W. E. G. G.		Philips Newing Son		2024 Orleans St. 31	

1000

No.

Warrant of Arrest

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

Return of Warrant

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09016

9043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>323 WORTHINGTON ROAD</u>		d. STREET ADDRESS <u>323 WORTHINGTON RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>JAMES</u> Last <u>ARIOSA JR.</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>8</u> - Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1955</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT J. ARIOSA SR.</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE SCHAAF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DOROTHY A. GRANSTON</u>		Address <u>1201 NORTHERN PKWY.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED PERITONITIS - GANGRENE</u> 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OF MECKELS DIVERTICULUM</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. FISHER</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/10/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARCE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. JENKINS & SONS Co.</u>		24a. REC'D BY REGISTRAR <u>SEP 10 1956</u>	
ADDRESS <u>4905 YORK RD.</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
FAMILY HISTORY		PREVIOUS ILLNESS		TOXIC SUBSTANCES		ALCOHOL		DRUGS		OTHER	
TESTS		X-RAY		AUTOPSY		LABORATORY		PATHOLOGICAL		OTHER	
FINDINGS		DISCUSSION		CONCLUSIONS		REMARKS		SIGNATURE OF EXAMINER		DATE	

RECEIVED
 SEP 11 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09017

9044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1407 Eastern Avenue				d. STREET ADDRESS 1505 E. Madison St.			
3. NAME OF DECEASED (Type or print) First Lee Middle Baker Last Baker				4. DATE OF DEATH Month September Day 17 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March , 1926		9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months 30 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Baker				14. MOTHER'S MAIDEN NAME Eleanor Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Henry Saunders 1505 E. Madison St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 934.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat capsized during storm					
20c. TIME OF INJURY Month, Day, Year Hour 9 o. m. 17 p. m. 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back River		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9/18/56			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 21, '56		22c. NAME OF CEMETERY OR CREMATORY Mount Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis				ADDRESS 1639 N. Broadway		24a. REC'D BY REGISTRAR SEP 19 1956	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 20 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the cause of death, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09018
43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md Back River		c. LENGTH OF STAY IN 1b 15 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1407 Eastern Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1027 Lamont Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last Ball		4. DATE OF DEATH Month Sept. Day 18 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1913
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 42 Days 4 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10b. KIND OF BUSINESS OR INDUSTRY Alabama	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Alice Ball 1027 Lamont	
17. INFORMANT Alice Ball 1027 Lamont		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 934.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Boat capsized during storm DUE TO (c) Boat capsized during storm		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat capsized during storm	
20c. TIME OF INJURY Month, Day, Year Hour X o. m. 9/17 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back River		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher		DATE SIGNED 9/18/56	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) White Arundel Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Larch L. Brown		24. REC'D BY REGISTRAR SEP 20 1956	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Edith Hurley	

RECEIVED

SEP 20 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 9946 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

09019

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 86 Mellor Ave.				e. STREET ADDRESS 86 Mellor Ave			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE SCHMIDT BASSLER				4. DATE OF DEATH Month Day Year Sept. 16 1936			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John Schmidt				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-0636		17. INFORMANT Mrs. Grace Jones, Catonsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease C DUE TO Hypertension (c)				INTERVAL BETWEEN ONSET AND DEATH Sudden 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/17 , 19 53 , to 9/17 , 19 56 , that I last saw the deceased alive on 8/16 , 19 56 , and that death occurred at 12:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Eliot W. Johnson M.D. 3432 Frederick Ave				ADDRESS (Street, city or town, state) DATE SIGNED 9/17/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-56		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR SEP 20 1956		24b. REGISTRAR'S SIGNATURE V. E. Harry	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Name of Deceased		Date of Death	
John Doe		April 15, 1956	
Age		Sex	
45		Male	
Race		Occupation	
White		Farmer	
Place of Birth		Cause of Death	
Baltimore, Md.		Heart Disease	
Date of Burial		Place of Burial	
April 17, 1956		Baltimore, Md.	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

RECEIVED
 SEP 20 1956
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09020

9247

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 12-25			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1mth 4dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland				d. STREET ADDRESS 3820 Cedar Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Mary Middle F. Last Bauer				4. DATE OF DEATH Month Sept. Day 19, Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1870	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Mens Shirt Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 22-07-9312		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Arteriosclerosis, generalized, severe. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 19 56 to Sept. 19, 19 56 , that I last saw the deceased alive on Sept. 19, 19 56 , and that death occurred at 9:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 9-19-56			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery,		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Verner				24a. REC'D BY REGISTRAR SEP 20 1956		24b. REGISTRAR'S SIGNATURE V. E. Barry	

[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 30

9048

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Route #2 - Brandywine, Md.			
3. NAME OF DECEASED (Type or print) First Katherine Middle Hooe Last Bay				4. DATE OF DEATH Month 9 Day 15 Year 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 23, 1907	
				9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Stenographer - Fed. Government				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Fitzhugh H. Billingsley				14. MOTHER'S MAIDEN NAME Georgia K. Lusby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE LEFT BREAST DUE TO (c) LOBAR PNEUMONIA						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LOBAR PNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 17, 1956 to Sept. 15, 1956 , that I last saw the deceased alive on Sept. 15, 1956 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9/15/56			
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.				Catonsville 28k Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/56		22c. NAME OF CEMETERY OR CREMATORY McKendree Cem.		22d. LOCATION (City, town, or county) (State) T. B. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Utilize Cross Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE 9/18/56		24b. REGISTRAR'S SIGNATURE Victor E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 11

SEP 20 1956

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9049

CERTIFICATE OF DEATH

09022

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cockeyville</i>		LENGTH OF STAY (In this place) <i>5 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rural-Cockeyville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Happy Hollow Rd</i>				STREET ADDRESS (If rural give location) <i>Happy Hollow Rd</i>			
3. NAME OF DECEASED (Type or Print) (First) <i>Edward</i> (Middle) <i>Anthony</i> (Last) <i>Bellin</i>				4. DATE OF DEATH (Month) <i>Sept</i> (Day) <i>26</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>21 December 1879</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Switzerland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alvin J Bellin</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Geiger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>NO</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>wife - same</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>						<i>7 or more minutes</i>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio-sclerotic cardiac vascular disease</i>						<i>5-15</i>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 25, 1956</i> , to <i>Sept 26, 1956</i> , that I last saw the deceased alive on <i>Sept 26, 1956</i> , and that death occurred at <i>11:15</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Keas</i>		M. D. <i>Carrollville Md</i>		ADDRESS (Street, city, town, state) <i>26 Sept 1956</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9/29/56</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i>		LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>	
24. REC'D BY REGISTRAR DATE <i>SEP 28 1956</i>		REGISTRAR'S SIGNATURE <i>Anne MacRae</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner & Sons - Balt 17, Md</i>		ADDRESS	

CERTIFICATE OF DEATH

Form 100-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DEPUTY SHERIFF

21. SIGNATURE OF JAILER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF CHIEF OF POLICE

24. SIGNATURE OF DEPUTY CHIEF OF POLICE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF DEPUTY SHERIFF

27. SIGNATURE OF JAILER

28. SIGNATURE OF WARDEN

29. SIGNATURE OF CHIEF OF POLICE

30. SIGNATURE OF DEPUTY CHIEF OF POLICE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF DEPUTY SHERIFF

33. SIGNATURE OF JAILER

34. SIGNATURE OF WARDEN

35. SIGNATURE OF CHIEF OF POLICE

36. SIGNATURE OF DEPUTY CHIEF OF POLICE

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF DEPUTY SHERIFF

39. SIGNATURE OF JAILER

40. SIGNATURE OF WARDEN

41. SIGNATURE OF CHIEF OF POLICE

42. SIGNATURE OF DEPUTY CHIEF OF POLICE

43. SIGNATURE OF SHERIFF

44. SIGNATURE OF DEPUTY SHERIFF

45. SIGNATURE OF JAILER

46. SIGNATURE OF WARDEN

47. SIGNATURE OF CHIEF OF POLICE

48. SIGNATURE OF DEPUTY CHIEF OF POLICE

49. SIGNATURE OF SHERIFF

50. SIGNATURE OF DEPUTY SHERIFF

51. SIGNATURE OF JAILER

52. SIGNATURE OF WARDEN

53. SIGNATURE OF CHIEF OF POLICE

54. SIGNATURE OF DEPUTY CHIEF OF POLICE

55. SIGNATURE OF SHERIFF

56. SIGNATURE OF DEPUTY SHERIFF

57. SIGNATURE OF JAILER

58. SIGNATURE OF WARDEN

BUREAU V. 8

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9050

CERTIFICATE OF DEATH

09024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3501 Putty Hill Ave.		d. STREET ADDRESS 3501 Putty Hill Ave.	
3. NAME OF DECEASED (Type or print) First Helen Middle M. Last Bieman		4. DATE OF DEATH Month Sept. Day 29 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1909
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher-Retired		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin F. Wilson		14. MOTHER'S MAIDEN NAME Georgeanna Willingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Louis H. Bieman	
17. INFORMANT Louis H. Bieman		Address 3501 Putty Hill Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Hypertension Cardio-Vascular Renal disease DUE TO (c) 10 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/27 , 19 56 , to 9/29 , 19 56 , that I last saw the deceased alive on 9/27 , 19 56 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Colburn Stewart M.D.		ADDRESS (Street, city or town, state) 6 E. Reed St Baltimore-2 Md	
PHYSICIAN'S NAME (Type) C. Wilbur Stewart		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE 4 1956		24b. REGISTRAR'S SIGNATURE Mrs. C. L. Roper	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALA.		MOBILE, ALA.		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1945		MOBILE, ALA.		MOBILE, ALA.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SUSPECTED CAUSE OF DEATH		SUSPECTED MANNER OF DEATH		SUSPECTED OCCUPATION	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		HEART DISEASE		NATURAL		DRIVER	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		SIGNATURE OF CORONER		DATE		PLACE	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENN.	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION	
APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	

BUREAU V. 8

OCT 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09025

9751 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspburg</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspburg</u>		
TOWN <u>Raspburg</u>			TOWN <u>Raspburg</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4515 Necker Ave.</u>			STREET ADDRESS (If rural, give location) <u>4515 Necker Ave.</u>		
3. NAME OF DECEASED (Type or Print) <u>Witold</u> (First) <u>Bildzukewicz</u> (Middle) <u></u> (Last)			4. DATE OF DEATH <u>Sept 1</u> 19 <u>57</u> (Month) (Day) (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 2, 1888</u>	9. AGE last birthday <u>67</u> yrs.	10. under 1 year If under 24 hrs. Months. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clockwork</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		
11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Bildzukewicz</u>			14. MOTHER'S MAIDEN NAME <u></u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)			16. SOCIAL SECURITY No. <u></u>		
17. INFORMANT AND ADDRESS <u>Mary Bildzukewicz 4515 Necker Ave.</u>					

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
(a) Immediate cause <u>Uremia</u>				<u>10 days</u>	
(b) Antecedent cause(s) <u>Asteroidar nephrosclerosis</u>				<u>1 year</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 15, 1956, to Aug. 1, 1957, that I last saw the deceased alive on Aug. 31, 1956, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>William Hanes</u>		ADDRESS <u>4200 Maple Rd. Balt. Md.</u>		DATE SIGNED <u>9-1-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Sept 4-56</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Gormanhill Rd Balto. Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>Sept 3 -</u>	REGISTRAR'S SIGNATURE <u>W. D. Reysnyder</u>	24. FUNERAL DIRECTOR <u>Huggel Bros.</u>		ADDRESS <u>7110 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 7 1956

BUREAU V. S.

9:52

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sherwood Road				d. STREET ADDRESS Sherwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leslie Middle Edward Last Birtcherd				4. DATE OF DEATH Month 9 Day 26 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1901		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Veneer Mfg.		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Birtcherd				14. MOTHER'S MAIDEN NAME Birdie ??			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-10-8493		17. INFORMANT Address Dorothy V. Birtcherd, Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver with Fatty Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Alcoholism (c) Chronic Alcoholism DUE TO (c) Chronic Alcoholism							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9/27/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-29-56	22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist		22d. LOCATION (City, town, or county) Sparks, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				24a. REC'D BY REGISTRAR 9/27/56		24b. REGISTRAR'S SIGNATURE Anna Bernier	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Name Cookseyville		Residence Cookseyville	
Street Sherman Road		City Cookseyville	
State Missouri		County Boone	
Age 25		Sex Male	
Date of Birth 1930		Date of Death 1956	
Cause of Death Chronic Alcoholism			
Manner of Death Natural			
Signature of Examiner _____			

RECEIVED
 OCT 2 1956
 BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9053

CERTIFICATE OF DEATH

09028

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>Owings Mills, Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Karen Lee Brace</u>	4. DATE OF DEATH Month Day Year <u>9 22 1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/55</u>
9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alvin Wentworth Brace</u>		14. MOTHER'S MAIDEN NAME <u>Edith Marian Hawley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severely increased intracranial pressure</u> DUE TO (b) <u>internal hydrocephalus</u> DUE TO (c) <u>Arnold-Chiari syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spina bifida and lumbar meningo-encephalocele</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Since birth</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-11</u> , 19 <u>55</u> , to <u>9-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Rich. G. Long (Pathologist)</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkview</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Long</u>		24a. REC'D BY REGISTRAR <u>9-23-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary D. Elmer</u>			

BUREAU V. 3

SEP 27 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09029

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>Md</u>		COUNTY <u>BALTO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE MANOR</u>		LENGTH OF STAY (In this place) <u>31 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE MANOR</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5940 CECIL AVE</u>		STREET ADDRESS (If rural give location) <u>5940 CECIL AVE</u>					
3. NAME OF DECEASED (Type or Print) <u>SAMUEL W. BROOKS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 9 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 4-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL W. BROOKS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>PRISCILLA C. CRUMBACKER 5940 CECIL AVE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>334X</u> <u>Respiratory asthmoidosis</u>						<u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>BRONCHOPNEUMONIA</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/1/56</u> , 19 <u>56</u> , to <u>9/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/9/56</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Benjamin Wills MD</u>				DATE SIGNED <u>9/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>SEPT 11-1956</u>		NAME OF CEMETERY OR CREMATORY <u>GRANITE PRES CEM</u>		LOCATION (City, town, or county) (State) <u>Granite Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. M. Walters</u>		ADDRESS <u>PRATT STRICKER STS</u>	
DATE <u>SEP 11 1956</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John W. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>Jan 15 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
10. SIGNATURE OF REGISTRAR <i>John D. Smith</i>		11. SIGNATURE OF WITNESSES <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		12. SIGNATURE OF CLERK <i>John D. Smith</i>	
13. SIGNATURE OF DECEASED <i>John W. Smith</i>		14. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		15. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
16. SIGNATURE OF DECEASED <i>John W. Smith</i>		17. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		18. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
19. SIGNATURE OF DECEASED <i>John W. Smith</i>		20. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		21. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
22. SIGNATURE OF DECEASED <i>John W. Smith</i>		23. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		24. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
25. SIGNATURE OF DECEASED <i>John W. Smith</i>		26. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		27. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
28. SIGNATURE OF DECEASED <i>John W. Smith</i>		29. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		30. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
31. SIGNATURE OF DECEASED <i>John W. Smith</i>		32. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		33. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
34. SIGNATURE OF DECEASED <i>John W. Smith</i>		35. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		36. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
37. SIGNATURE OF DECEASED <i>John W. Smith</i>		38. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		39. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
40. SIGNATURE OF DECEASED <i>John W. Smith</i>		41. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		42. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
43. SIGNATURE OF DECEASED <i>John W. Smith</i>		44. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		45. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
46. SIGNATURE OF DECEASED <i>John W. Smith</i>		47. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		48. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
49. SIGNATURE OF DECEASED <i>John W. Smith</i>		50. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		51. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
52. SIGNATURE OF DECEASED <i>John W. Smith</i>		53. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		54. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
55. SIGNATURE OF DECEASED <i>John W. Smith</i>		56. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		57. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
58. SIGNATURE OF DECEASED <i>John W. Smith</i>		59. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		60. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
61. SIGNATURE OF DECEASED <i>John W. Smith</i>		62. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		63. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
64. SIGNATURE OF DECEASED <i>John W. Smith</i>		65. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		66. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
67. SIGNATURE OF DECEASED <i>John W. Smith</i>		68. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		69. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
70. SIGNATURE OF DECEASED <i>John W. Smith</i>		71. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		72. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
73. SIGNATURE OF DECEASED <i>John W. Smith</i>		74. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		75. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
76. SIGNATURE OF DECEASED <i>John W. Smith</i>		77. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		78. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
79. SIGNATURE OF DECEASED <i>John W. Smith</i>		80. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		81. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
82. SIGNATURE OF DECEASED <i>John W. Smith</i>		83. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		84. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
85. SIGNATURE OF DECEASED <i>John W. Smith</i>		86. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		87. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
88. SIGNATURE OF DECEASED <i>John W. Smith</i>		89. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		90. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
91. SIGNATURE OF DECEASED <i>John W. Smith</i>		92. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		93. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
94. SIGNATURE OF DECEASED <i>John W. Smith</i>		95. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		96. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
97. SIGNATURE OF DECEASED <i>John W. Smith</i>		98. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		99. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	
100. SIGNATURE OF DECEASED <i>John W. Smith</i>		101. SIGNATURE OF SURVIVORS <i>John W. Smith, Jr.</i> <i>John W. Smith, Sr.</i>		102. SIGNATURE OF NEAREST RELATIVE <i>John W. Smith, Jr.</i>	

BUREAU V. 3

SEP 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09030

CERTIFICATE OF DEATH

Reg. Dist. No. 30

9055

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY B. Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Tyrrel Middle Snyder Last Brown		4. DATE OF DEATH Month September Day 14 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Electric Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel E. Brown		14. MOTHER'S MAIDEN NAME Judith Yowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerulonephritis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic abdominal aortic aneurysm			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 19 56 to Sept. 14, 19 56 , that I last saw the deceased alive on Sept. 14, 19 56 , and that death occurred at 3:20 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-14-56 ACTUAL SIGNATURE Stella Wachslar M.D. Stella Wachslar, M. D. PHYSICIAN'S NAME (Type) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/56	
22c. NAME OF CEMETERY OR CREMATORY Ledar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home		24. REGISTRAR'S SIGNATURE Victor E. Harry	

BUREAU V. 3

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9027 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

090321
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore 22</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt. 22</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (Balt 22)</u> d. STREET ADDRESS <u>1954 MARSHALL Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>William MAURICE Buckley</u>				4. DATE OF DEATH 9 Month 8 Day 1956											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-5-84</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. Office Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USS</u>			
13. FATHER'S NAME <u>JOHN BUCKLEY</u>						14. MOTHER'S MAIDEN NAME									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>IDA M. CURTIS 1854 MARSHALL</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Jack C Collins</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						<u>9-8-56</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>9/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. COMFORT</u>				22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA VA</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ULLRICH FUNERAL HOME 2112 DUNDALK ST</u>						24a. REC'D BY REGISTRAR DATE <u>SEP 11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Thos. P. Kelly</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

9728

CERTIFICATE OF DEATH

09033

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH o. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE AS b. COUNTY SAME	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PUNDAK 22		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) 28 EASTSHIP Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARTLEY EDWARD BURKE, SR.		4. DATE OF DEATH 9-26-56	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 14, 1911	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BURNER		12. KIND OF BUSINESS OR INDUSTRY SHIP CONSTR.	
13. BIRTHPLACE (State or foreign country) PENNA		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME JOHN F. BURKE		16. MOTHER'S MAIDEN NAME HATTIE HARDY	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. 213-07-7520	
19. INFORMANT KATHLEEN B. BURKE - SAME		20. ADDRESS	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		22. INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) trip	
27. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		28. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		30. (City or town) (County) (State)	
31. I certify that I attended the deceased from 9-26-56 , to 9-26-56 , that I last saw the deceased alive on 9-26-56 , and that death occurred at 6:30 PM , from the causes and on the date stated above.		32. ADDRESS (Street, city or town, state) 16800 MORNINGSTAR RD - DUNDALK MD	
33. ACTUAL SIGNATURE M.B. DAVIS		34. DATE SIGNED 9/28/56	
35. PHYSICIAN'S NAME (Type) M.B. DAVIS MD		36. MEDICAL CERTIFICATION	
37. BURIAL, CREMATION, (REMOVAL Specify) BURIAL		38. DATE THEREOF 9-29-56	
39. NAME OF CEMETERY OR CREMATORY OAKED HEART CEM.		40. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
41. FUNERAL DIRECTOR'S SIGNATURE North Ave. Burial, Dundalk, Md.		42. ADDRESS	
43. REC'D BY REGISTRAR 1956		44. REGISTRAR'S SIGNATURE John M. Kelly	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

BUREAU V. S.

OCT 1 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9056 CERTIFICATE OF DEATH

09034

Reg. Dist. No. 47

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE Md.		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 29		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 29			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4403 Wilkins Ave.				STREET ADDRESS (If rural give location) 4403 Wilkins Ave.			
3. NAME OF DECEASED (Type or Print) Thomas Victor Burnham				4. DATE OF DEATH (Month) Sept. (Day) 23 (Year) 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 27, 1885.	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Mfrgr.			10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 213-05-7009		17. INFORMANT & ADDRESS Mrs. Vera Hampton-3826 Elmora Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
421.0 IMMEDIATE CAUSE (A) Myocardial Infarction						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSE(S) DUE TO (B) Myocardial Infarction - Anterior						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Sept 20, 1956, to Sept 23, 1956, that I last saw the deceased alive on Sept 20, 1956, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE John F. Coolahan M.D.				ADDRESS (Street, city, town, state) 4201 Wilkins Ave		DATE SIGNED 9/24/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/26/1956		NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR SEP 26 1956		REGISTRAR'S SIGNATURE Dr. Geo. M. Kieffer		25. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Hgts.	

CERTIFICATE OF DEATH

Form No. 10-1

1. Name of deceased (Print or type full name)

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial society

19. Signature of religious society

20. Signature of other

21. Signature of other

22. Signature of other

23. Signature of other

24. Signature of other

25. Signature of other

26. Signature of other

27. Signature of other

28. Signature of other

29. Signature of other

30. Signature of other

31. Signature of other

32. Signature of other

33. Signature of other

34. Signature of other

35. Signature of other

36. Signature of other

37. Signature of other

38. Signature of other

39. Signature of other

40. Signature of other

41. Signature of other

42. Signature of other

43. Signature of other

BUREAU V. 3

SEP 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09035

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 3 1/2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN THE PINES				d. STREET ADDRESS BALTIMORE ST.			
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL B. BUSEY				4. DATE OF DEATH Month Day Year SEPTEMBER 4 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 30 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY COTTON MILL	
11. BIRTHPLACE (State or foreign country) SAVAGE, MD				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM BUSEY				14. MOTHER'S MAIDEN NAME MARTHA TUCKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-5035		17. INFORMANT Address MRS DOROTHY MAY HUGH SAVAGE, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vas. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 4 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19____, to 9/4/56 , 19____, that I last saw the deceased alive on 9/4/56 , 19____, and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED 9/5/56							
ACTUAL SIGNATURE Frank E. Shipley M.D.				PHYSICIAN'S NAME (Type) Frank E. Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/9/56		22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		22d. LOCATION (City, town, or county) (State) Savage - Howard - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Willard R. ...				ADDRESS ...		24a. REC'D BY REGISTRAR DATE SEP 10 1956	
24b. REGISTRAR'S SIGNATURE T. E. ...							

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,2 FilmG202 9-10-56 et
9058
CERTIFICATE OF DEATH

09036
30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1084 St. Agnes Lane</u>				d. STREET ADDRESS <u>1084 St. Agnes Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BROOK</u> Middle <u>L.</u> Last <u>BUXTON</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Thomas Buxton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. - (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-12-1903</u>		17. INFORMANT <u>Mr. Leonard J. Buxton - 405 Central Ave., Towson</u> Address <u>Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, sigmoid, with generalized metastases</u> DUE TO <u>153x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 mo.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-26-56</u> , 19 <u>56</u> , to <u>9-1-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-1-56</u> , 19 <u>56</u> and that death occurred at <u>4.05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Schaefer</u> JOHN F. SCHAEFER 401 Random Road, Balto. 29, Md.				ADDRESS (Street, city or town, state) <u>401 Random Road Balto. 29 Md.</u> DATE SIGNED <u>SEP 4 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker</u>				ADDRESS <u>Balto 17 Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Harry</u>	

SEP 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

09037
37

9059

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3521 ROLLING Rd.				d. STREET ADDRESS 3521 ROLLING Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDNA Middle ALMOND Last BYRNE				4. DATE OF DEATH Month 9 Day 8 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/82	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN ALMOND				14. MOTHER'S MAIDEN NAME ANGELINA WINKS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —			
17. INFORMANT DAUGHTER-MRS PEARCE				Address 3521 ROLLING Rd, BALTO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) HYPERTENSIVE CARDIO-VASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH ONE MONTH TWO MONTHS 30 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MARCH 10, 1952 to Sept 8, 1956 , that I last saw the deceased alive on Sept 7, 1956 , and that death occurred at 1:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont				M.D. 8204 LIBERTY Rd, BALTO. Md. DATE SIGNED 9/8/56			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT M.D.				ADDRESS 8204 LIBERTY Rd, BALTO. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edwin L. Pierpont				24a. REC'D. BY REGISTRAR Dr. Wm. E. Martin			
24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin				DATE SEP 10 1956			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		12/14/20		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES		4/4/68		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

SEP 11 1966

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09038

9060

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>802 Range Court</u>		STREET ADDRESS (If rural give location) <u>802 Range Court</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Gustav</u> (Middle) <u>E.</u> (Last) <u>Carlstrand</u>		(Month) <u>Sept.</u> (Day) <u>23</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 27, 1881</u>
		9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Vice Pres. Contracting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>	11. BIRTHPLACE (State or foreign country) <u>Sweden</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Mrs. G.E. Carlstrand 802 Range Ct.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4201 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary sclerosis + coronary occlusion</u>		<u>3 mths ago</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>		<u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.) <u>None</u>	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May, 1956</u> , to <u>Sept 23, 1956</u> , that I last saw the deceased alive on <u>Sept 23 19 56</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Maurice Feldman</u>		ADDRESS (Street, city, town, state) <u>Shelton, Balto 2 Md</u> DATE SIGNED <u>9/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>9-25-56</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>
24. REC'D BY REGISTRAR <u>SEP 28 1956</u>	REGISTRAR'S SIGNATURE <u>Mabel Guy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home - Catonsville, Md.</u> ADDRESS	

BUREAU V. S.

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9061

CERTIFICATE OF DEATH

Reg. Dist. No.

09039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. LENGTH OF STAY IN 1b 7 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall, 19 Harrison Avenue				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Twin River Beach, Balto., 20 Md.			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Carroll				4. DATE OF DEATH Month September Day 27 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen., Mdse., Phila., Pa.,		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Carroll				14. MOTHER'S MAIDEN NAME Elizabeth Rembold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Matilda A. Carroll, Balto., 20 Md., Route 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of prostate DUE TO (c) 18 mos.						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 14, 1955 , to September 27, 1956 , that I last saw the deceased alive on Sept 25, 1956 , and that death occurred at 8:30 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harvey L. Fuller M.D.				ADDRESS (Street, city or town, state) Ridge Rd, Baltimore DATE SIGNED md			
PHYSICIAN'S NAME (Type) Harvey L. Fuller, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1956		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son				ADDRESS Abingdon Md		24a. REC'D BY REGISTRAR DATE 10/4/56	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

BUREAU V. S.

9551 6 OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0904044

9062

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 4 Hrs. 20 M.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last CHALK		4. DATE OF DEATH Month September Day 25 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobiles	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles M. Chalk		14. MOTHER'S MAIDEN NAME Violet G. Warfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW II (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 218-10-0842	
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PLEURISY WITH EFFUSION, LEFT 003.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF LIVER - DURATION UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 24, 1956 , to September 25, 1956 , that he was deceased live only 12 hours , and that death occurred at 3:00 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND 9/25/56			
ACTUAL SIGNATURE Francis G. Dickey			
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		24. REC'D BY REGISTRAR 6009 Harford Road Baltimore 11, Md.	
24b. REGISTRAR'S SIGNATURE Dawson L. Farley		24c. DATE SEP 1 1956	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

OCT 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09041

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7 Maple Avenue		d. STREET ADDRESS 7 Maple Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Coale		4. DATE OF DEATH Month Day Year September 15 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1885
9. AGE (In years full birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Hook		14. MOTHER'S MAIDEN NAME Julia A. Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO CORONARY OCCLUSION Sudden		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 9/17/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18, 1956	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		24a. REC'D BY REGISTRAR Sept. 17, 1956	
ADDRESS Towson, Maryland		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

BUREAU V. S.

SEP 19 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09042

9064

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 56 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) 117 SANFORD AVE.		d. STREET ADDRESS 117 SANFORD AVE.	
3. NAME OF DECEASED (Type or print) TURNER POULSON COE		4. DATE OF DEATH Month SEPT. Day 1ST Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 8, 18
9a. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LETTER CARRIER U.S. POST OFFICE WEST VA.		10b. KIND OF BUSINESS OR INDUSTRY U.S.A.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM G WYNN COE		14. MOTHER'S MAIDEN NAME ANNIE ELIZABETH ARMSTRONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CLARENCE B. COE		17. ADDRESS CATONSVILLE-28, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1030 (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-13 , 19 56 , to 9-1 , 19 56 , that I last saw the deceased alive on 8-31 , 19 56 , and that death occurred at 1:40 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Witmer K. Gallagher		ADDRESS (Street, city or town, state) 6209 Frederick Ave. Catonsville-28, Md.	
PHYSICIAN'S NAME (Type) Witmer K. Gallagher		DATE SIGNED 9-1-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-4-1956	
22c. NAME OF CEMETERY OR CREMATORY LOUNDON PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons		ADDRESS CATONSVILLE MD.	
24a. REC'D BY REGISTRAR DATE 9-4-56		24b. REGISTRAR'S SIGNATURE Victor E. Harris	

CERTIFICATE OF DEATH

RECEIVED
SEP 7 1956
BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

CERTIFICATE OF DEATH

NAME: WILLIAM OWEN GUNN

AGE: 70

SEX: Male

RACE: White

DATE OF BIRTH: July 3, 1886

DATE OF DEATH: August 1, 1956

PLACE OF BIRTH: Worcester, Massachusetts

PLACE OF DEATH: Worcester, Massachusetts

RESIDENT ADDRESS: 100 West Main Street, Worcester, Massachusetts

DEATH CERTIFICATE NO.: 100-1000000000

REGISTRATION NO.: 100-1000000000

DATE OF REGISTRATION: August 1, 1956

REGISTRAR: John J. Connelley

DEATH CERTIFICATE NO.: 100-1000000000

REGISTRATION NO.: 100-1000000000

DATE OF REGISTRATION: August 1, 1956

REGISTRAR: John J. Connelley

9065

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.CO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Town</u>		LENGTH OF STAY (in this place) <u>50 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Town</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7924 BEVERLY RD.</u>				STREET ADDRESS (If rural give location) <u>7924 BEVERLY RD.</u>			
3. NAME OF DECEASED: (Type or Print) <u>ANNA MARIE COLACCE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9 - 11 - 1956</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>9-27-1890</u>	
9. AGE last birthday <u>65</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>HOUSEWORK AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOSEPH RAFFA</u>				14. MOTHER'S MAIDEN NAME: <u>THERESA STANA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>—</u>		17. INFORMANT & ADDRESS: <u>MRS. FRANK LIBERTINI (SAME)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>acute Coronary Infarction</u>							
ANTECEDENT CAUSE (S) (B) <u>Ch Coronary artery Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ch Diabetes</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR? <u>—</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1941, to <u>Sept 9</u> , 1956, that I last saw the deceased alive on <u>Sept 9</u> , 1956, and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ach. Hornstein</u>		ADDRESS <u>M.D. 204 E. Bidale St</u>		DATE SIGNED <u>9/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9-15-1956</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-14-56</u>		REGISTRAR'S SIGNATURE <u>G.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>G.W. Hedrick</u>		ADDRESS <u>5444 BELAIR RD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45



9033

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Relay</u>	STATE <u>Md</u> COUNTY <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Relay</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1548 S. Rolling Rd</u>		STREET ADDRESS (If rural give location) <u>1548 S. Rolling Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Louis Joseph Call</u>		OF DEATH: <u>Sept 21</u> 19 <u>56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Feb 19, 1893</u>
9. AGE last birthday <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>grocer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Balta & Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Edw. James Call</u>		14. MOTHER'S MAIDEN NAME: <u>Julia A Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>218-22-2097</u>	
17. INFORMANT & ADDRESS: <u>Mrs Mary Rebecca Call</u>		<u>1548 S. Rolling Rd</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE (A) <u>acute coronary occlusion</u>		<u>1 hr</u>
ANTECEDENT CAUSE (S): (B) <u>Coronary Heart Disease</u>		<u>2 wks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>General Arterio Sclerosis</u>		<u>5 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental Dispondency</u>		<u>6 mo.</u>

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 20, 1956, to Sept 21, 1956 that I last saw the deceased alive on Sept 20, 1956, and that death occurred at 5:30 M, from the causes and on the date stated above.

SIGNATURE [Signature] DATE SIGNED Sept 21, 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 9/24/56 NAME OF CEMETERY OR CREMATORY Grace Church & Cemetery LOCATION (City, town, or county) (State) Relay Md

DATE REC'D BY LOCAL REGISTRAR Sept 22 56 REGISTRAR'S SIGNATURE [Signature] 24. FUNERAL DIRECTOR [Signature] ADDRESS [Address]

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D. C. 20540

SEP 25 1956

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BUREAU OF HEALTH

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SEP 25 1956

RECEIVED

9066

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. LENGTH OF STAY IN 1b <u>3y 01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1904 McCulloh Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Luvenia</u> Middle <u>May</u> Last <u>Conyer</u>				4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1991</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemaid</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George Rhubottom</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>Sophia Brown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Dr. Louis Dalmau, Pikesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart Insufficiency, H. C. U. I.</u> DUE TO (c) <u>Arterio Sclerosis, generalized</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 mts</u> <u>?</u> <u>at least 10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypothyroidism. Thyroidectomy years ago (J. Hopkins)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pikesville & Baltimore Md</u>	
20f. (City or town) (County) (State) <u>Pikesville & Baltimore Md</u>				21. I certify that I attended the deceased from <u>Sept 18, 1956</u> to <u>Sept 18, 1956</u> , that I last saw the deceased alive on <u>Sept 18, 1956</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Dalmau</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1413 Reisterstown Road Pikesville 8, Md 9/18/56</u>			
PHYSICIAN'S NAME (Type) <u>Louis Dalmau, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Lunn</u>				24. REC'D BY REGISTRAR <u>SEP 24 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Sorothy Purcell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

SEP 24 1956

RECEIVED

9067

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cowenton Ave.		d. STREET ADDRESS Cowenton Ave.	
3. NAME OF DECEASED (Type or print) First Emma Middle Smith Last Cook		4. DATE OF DEATH Month Sept. Day 23 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Mary Holtzner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-6302	
17. INFORMANT Henry H. Cook		Address Cowenton Ave. White Marsh, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) Arteriosclerotic Cardio-Vascular disease (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1, 1956 to Sept 23, 1956 , that I last saw the deceased alive on Sept 23, 1956 , and that death occurred at 8 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. Cunningham M.D.		ADDRESS (Street, city or town, state) Baltimore Md. DATE SIGNED 9/24/56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR 26 1956	
ADDRESS 2401 Belair St.		24b. REGISTRAR'S SIGNATURE Dr. Walter Bennett	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7510

RECEIVED

PLEASE WRITE PLAINLY IN UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9068

CERTIFICATE OF DEATH

Reg. Dist. No.

09047

38

1. NAME OF DECEASED (Type or Print) <u>[Baby] David Lloyd Cooper</u>			2. DATE OF DEATH <u>Sept. 22, 1956</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore County</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>6210 Falls Road</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>6210 Falls Road</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Infant</u>	8. DATE OF BIRTH <u>Sept. 9, 1956</u>	9. AGE (In years last birthday) <u>13</u>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Sterling Cooper</u>			14. MOTHER'S MAIDEN NAME <u>Emily Hall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT'S NAME AND ADDRESS <u>Mr. Sterling Cooper</u> <u>6210 Falls Road</u>		
18. <u>762.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Atelantosis</u> (A) _____ DUE TO ANTECEDENT CAUSES (B) _____ DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 9, 1956</u> , to <u>Sept 22, 1956</u> , that I last saw the deceased alive on <u>Sept 22, 1956</u> and that death occurred at <u>6:00 a.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Robert W. Newkirk</u>		23B. ADDRESS <u>420 N. Gilmor St.</u>		23C. DATE SIGNED <u>9/24/56</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sept. 24, 1956</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	
24D. LOCATION (City, town, or county) (State) <u>Crown, Md.</u>		25. FUNERAL DIRECTOR <u>Funeral Home</u> <u>1631 Druid Hill Ave.</u>			
DATE RECEIVED BY LOCAL REGISTRAR <u>SEP 24 1956</u>		REGISTRAR'S SIGNATURE <u>Malcolm</u>			

RECEIVED

SEP 27 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9069

CERTIFICATE OF DEATH

Reg. Dist. No.

09048-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>				c. LENGTH OF STAY IN 1b <u>72 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address, OR INSTITUTION) <u>Middletown Rd.</u>				d. STREET ADDRESS <u>Middletown Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Laura L Cooper</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27, 1884</u>	
9. AGE (In years <u>72</u> yrs.)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Line, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Abraham Krout</u>				14. MOTHER'S MAIDEN NAME <u>Grazella Waltemyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Harry N. Cooper, Parkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9040</u> (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of neck of left femur</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Felldown</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8/15/56</u> 19 p. m. <u>9</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Parkton</u> (County) <u>Walt.</u> (State) <u>Md.</u>							
21. I certify that I attended the deceased from <u>8/15</u> , 19 <u>56</u> , to <u>9/3/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/3/56</u> , 19 <u>56</u> , and that death occurred at <u>10:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D. <u>Parkton, Md.</u>				DATE SIGNED <u>9/5/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>				<u>Parkton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 6, 1956</u>		<u>Wiseburg Cemetery</u>		<u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24. REC'D BY REGISTRAR <u>9/6/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Sullivan</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1955		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Other		Remarks	
Teacher		Married		High School		Catholic		White		White		None		Occasional		Daily		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Scientist		Signature of Anthropologist		Signature of Archaeologist		Signature of Historian	
None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09049

9070

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa - Bellona Ave.				d. STREET ADDRESS 1303 Bolton St.					
3. NAME OF DECEASED (Type or print) First FRANCES Middle G. Last CORRIGAN				4. DATE OF DEATH Month Sept. Day 19 Year 1956					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1876			
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) - unknown Md.		12. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) rd. Saleslady				10b. KIND OF BUSINESS OR INDUSTRY one's store					
13. FATHER'S NAME James Corrigan				14. MOTHER'S MAIDEN NAME Frances Cain					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. D. O. Tracy - 1307 John St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronch. pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arterio-sclerosis (c) -								INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from 19.10. to death , that I last saw the deceased alive on Sept. 18, 1956 , and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 13 E Sagar St, Balto, Md. DATE SIGNED Sept 19, 56									
ACTUAL SIGNATURE E. H. Hayward				M.D. 13 E Sagar St, Balto, Md.					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/56		22c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cem.		22d. LOCATION (City, town, or county) (State) Hickory, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, Balto. 17, Md.				24a. REC'D BY REGISTRAR 9/24/56		24b. REGISTRAR'S SIGNATURE Mabel Gray			

WARTLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9034

CERTIFICATE OF DEATH

09050

Reg. Dist. No.

42

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1269 Poplar Avenue		d. STREET ADDRESS 1269 Poplar Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle M. Last Coursey		4. DATE OF DEATH Month September Day 11 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel A. Gough		14. MOTHER'S MAIDEN NAME Mary Kuhn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank N. Coursey		Address 1269 Poplar Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Carcinoma of left Breast with 170X DUE TO multiple metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 22, 1955 , to Sept 11, 1956 , that I last saw the deceased alive on Aug 29, 1956 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Arthur Rossberg		M.D. 2436 Washington Blvd 9/12/56	
PHYSICIAN'S NAME (Type) CARTHUR ROSSBERG MD		Baltimore 30, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-56	
22c. NAME OF CEMETERY OR CREMATORY Touken Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR SEP 14 1956		24b. REGISTRAR'S SIGNATURE Dr. C. M. Kieffer	

MARYLAND STATE DEPARTMENT OF HEALTH

9071

2411 N. Charles Street, Baltimore

09051

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sparrows Pt</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Essex</u>	
TOWN <u>Forest Lodge</u>		TOWN <u>Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Forest Lodge</u>		STREET ADDRESS (If rural give location) <u>957 Woodlyn Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Bessie</u>	(First) <u>L.</u> (Middle) <u>Cox</u> (Last)	4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 14, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>60</u> yrs. <u>85</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Obie Belcher</u>		14. MOTHER'S MAIDEN NAME <u>Trace Zimmerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>957</u>	
17. INFORMANT <u>Mrs. Trace Zimmerman</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260x Immediate cause (a) <u>Hypostatic Pneumonia</u>		
Antecedent cause(s)		3 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cerebral Thrombosis</u>		
(c) <u>Diabetes Mellitus</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

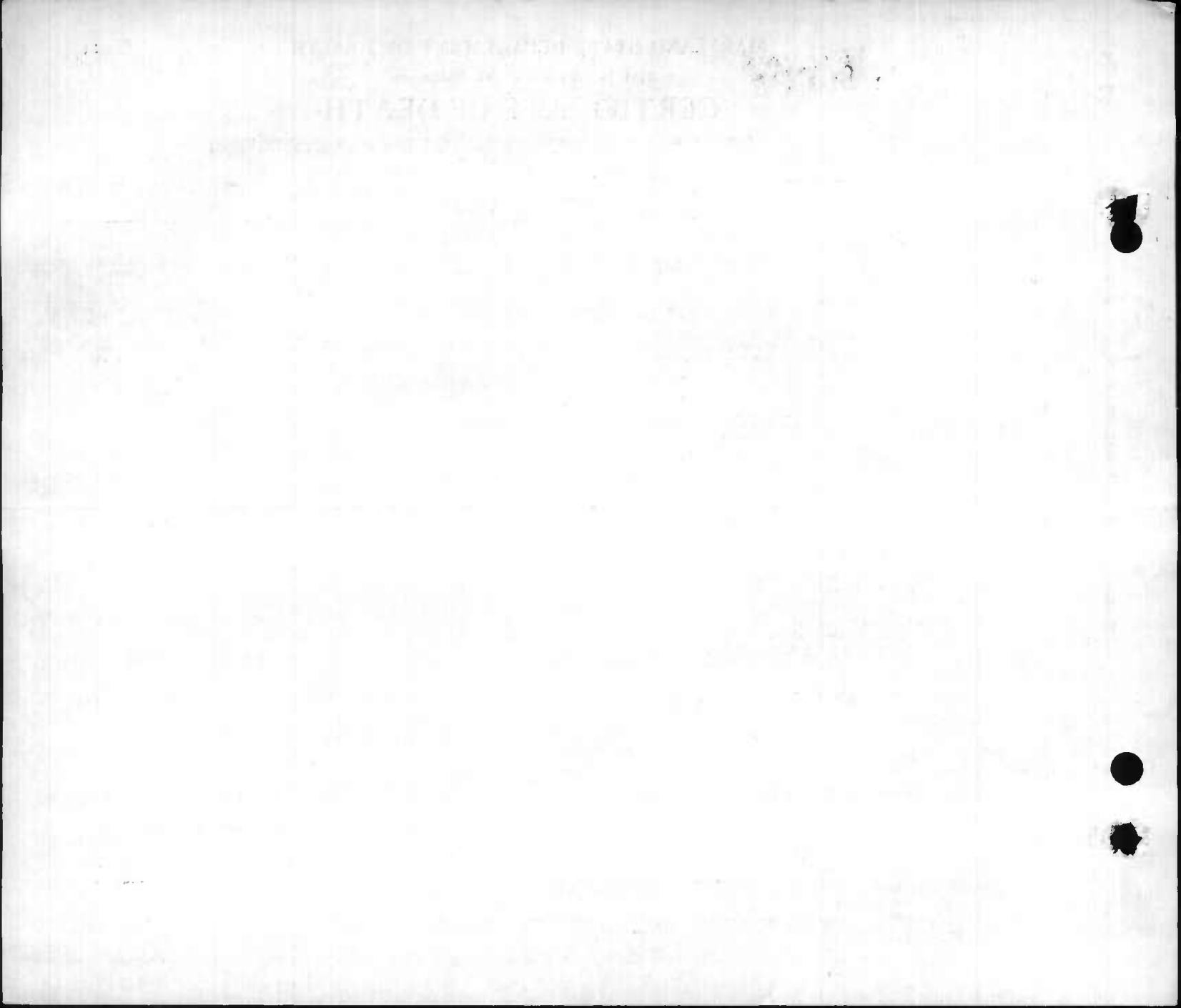
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1, 1954, to Sept. 7, 1956, that I last saw the deceased alive on Sept. 7, 1956, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

SIGNATURE <u>James G. Mans</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>520 D St Balto 19 Md</u>	DATE SIGNED <u>9/7/56</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>9/1/56</u>	NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cem.</u>	LOCATION (City, town, or county) (State) <u>Bluefield Va</u>
DATE REC'D BY LOCAL REG <u>9-7-56</u>	REGISTRAR'S SIGNATURE <u>SM</u>	24. FUNERAL DIRECTOR <u>Lemondy Kuck</u>	ADDRESS <u>5305 Rayford</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9072

CERTIFICATE OF DEATH

Reg. Dist. No.

09052

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 64.9 m.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 287 DALLAS COURT	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE CRAWFORD		4. DATE OF DEATH Month Day Year 9 9 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY D. CRAWFORD		14. MOTHER'S MAIDEN NAME SALLIE HOYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT CATHERINE CRAWFORD		Address 287 DALLAS COURT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the right lung DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 3, 1950 , to Sept. 9, 1956 , that I last saw the deceased alive on Sept. 9, 1956 , and that death occurred at 2:00 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED SPRING GROVE STATE HOSPITAL 9-10-56	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 12, 1956	22c. NAME OF CEMETERY OR CREMATORY Cathlamet Cemetery	22d. LOCATION (City, town, or county) (State) Eastern Ave Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Krause Funeral Home		ADDRESS 1216 S Charles St	
23a. RECEIVED BY REGISTRAR SEP 17 1956		23b. REGISTRAR'S SIGNATURE T. E. Harvey	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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REMARKS

Findings

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СРЕДСТВО ЗАЩИТЫ

BUREAU A.

SEP 17 1956

RECEIVED

9073 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09053

Reg. Dist. No.

34

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6001 Gwynn Oak Ave.				d. STREET ADDRESS 6001 Gwynn Oak Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HAMILTON Middle CLARKE Last CRUIKSHANK				4. DATE OF DEATH Month Sept. Day 13, Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1912	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Lumberport, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Dr. Dwight P. Cruikshank				14. MOTHER'S MAIDEN NAME Coral Sharpe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE				16. SOCIAL SECURITY NO. 218-14-4845		17. INFORMANT Mary Grace Cruikshank (wife) same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 9/13/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Mem. Pk.	
				22d. LOCATION (City, town, or county) (State) Grafton, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS				ADDRESS - North & Pa. Balto Md.		24a. REC'D BY REGISTRAR DATE 9-14-56	
				24b. REGISTRAR'S SIGNATURE <i>Dr. Hon. E. Martin</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name		Sex		Age	
Race		Color		Birth Date	
Birth Place		Residence		Occupation	
Cause of Death		Manner of Death		Time of Death	
Place of Death		Signature of Examiner		Date	

RECEIVED
SEP 17 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9074

Items 3, 14 Film G204 9-21-56 et

CERTIFICATE OF DEATH

09054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2701 Wildberger Ave</u>				d. STREET ADDRESS <u>2701 Wildberger Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mr. Harry</u> Middle <u>Van Porson</u> Last <u>De Graw</u>				4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Portsmouth, Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William H. De Graw</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen (Maiden name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>191X</u>		17. INFORMANT <u>Mr. E. De. Gram</u> Address <u>2701 Wildberger Ave #14</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>191X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of face-neck etc</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 month</u> <u>2 year.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept 13</u> , 19 <u>56</u> , to <u>Sept 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Harold H Burns</u> M.D. <u>115 E. Bager St.</u> <u>9-14-56</u> PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>Sept. 18, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

BUREAU V. S.

SEP 19 1956

RECEIVED

9029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
c. LENGTH OF STAY IN 1b 36 years		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Township	
3. NAME OF DECEASED (Type or print) ELEANOR DENNICK		4. DATE OF DEATH Month Sept. Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1874
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph W. Schofield		14. MOTHER'S MAIDEN NAME Anna Mc Vey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wm. H. Beard		Address 6801 Mornington Road-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio-Vas. Disease-10-413. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10-413.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atrophic ARTHRITIS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18, 1954 to Sept 30, 1956 , that I last saw the deceased alive on Sept 30, 1956 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Davis		DATE SIGNED 6800 Mornington Road 10/1/56	
PHYSICIAN'S NAME (Type) M.B. DAVIS M.D.		Dundalk-22 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 2, 1956	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Wm. Kelly		OCT 4 1956	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9035

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balb</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Landedowne</u>		<u>13 yrs</u>		OR TOWN <u>Landedowne</u>		<u>51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2942 Hammond Ferry Rd</u>				STREET ADDRESS (If rural give location) <u>2942 Hammond Ferry Rd</u>			
3. NAME OF DECEASED: (First) <u>Luther</u> (Middle) <u>Monroe</u> (Last) <u>Dowdy</u>				4. DATE OF DEATH: (Month) <u>Sept</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Apr 3-1874</u>	
				9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>building</u>		11. BIRTHPLACE (State or foreign country): <u>Giles County, Virginia</u>	
13. FATHER'S NAME: <u>Chasbit Dowdy</u>				14. MOTHER'S MAIDEN NAME: <u>Nancy Richardson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>yes</u>				16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Ella Covey - 2942 Hammond Ferry Rd</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebro-vascular hemorrhage</u>		<u>2 days</u>	
Antecedent causes (s) (b) <u>arteriosclerosis</u>		<u>years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>					
19a. DATE OF OPERATION: <u>none</u>				19b. MAJOR FINDINGS OF OPERATION: <u>none</u>	
21. ACCIDENT (Specify) <u>none</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>none</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> m.		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> , to <u>29 Sept 1956</u> , that I last saw the deceased alive on <u>29 Sept 1956</u> , and that death occurred at <u>7:00 PM</u> ; from the causes and on the date stated above.					
SIGNATURE <u>William J. Johnson, M.D.</u>		(Degree or title)		ADDRESS <u>1328 Sulphur Sp. Rd -</u>	
DATE SIGNED <u>29 Sept 56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>Oct 5, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
DATE REC'D BY LOCAL REGISTRAR <u>10-7-56</u>		REGISTRAR'S SIGNATURE <u>C</u>		24. FUNERAL DIRECTOR <u>Ambrase, Inc. 1328 Sulphur Sp. Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EAGLE-A
ACQUITTANCE BOARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9075

CERTIFICATE OF DEATH

090578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2108 Taylor Avenue</u>		d. STREET ADDRESS <u>2108 Taylor Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Maurice Duca</u>		4. DATE OF DEATH <u>September 1 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Peter Duca</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Rose Duca, 2108 Taylor Ave #14</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER. Lung.</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/28/50</u> , 19____, to <u>9/1/56</u> , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lawrence M. Serra</u>		M.D. <u>11 East Chase Street, Baltimore 2, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Lawrence M. Serra</u>		signed <u>September 4, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/6/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>SEP 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9076

CERTIFICATE OF DEATH

09058
37

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium Heights				c. LENGTH OF STAY IN 1b 9 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAURA ELIZABETH EARLE				4. DATE OF DEATH Month Day Year September, 9th 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15th. 1899	
9. AGE (In years last birthday) yrs. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Maid		10b. KIND OF BUSINESS OR INDUSTRY Restuarant Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John D. Kearsey			
14. MOTHER'S MAIDEN NAME Sarah Daughton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No			
16. SOCIAL SECURITY NO. 220-24-0530				17. INFORMANT Mrs Wm.H.Baker			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from JAN. 2nd 1956 , to Sept. 1956 , that I last saw the deceased alive on Sept. 4th 1956 , and that death occurred at 3 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Kevin Quinn M.D. 1927 York Rd. Timonium				DATE SIGNED Sept. 9th 1956			
PHYSICIAN'S NAME (Type) M. Kevin Quinn				ADDRESS (Street, city or town, state) York Road, Timonium, Balto Co. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept.		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Lamoreau				24a. REC'D BY REGISTRAR SEP 13 1956		24b. REGISTRAR'S SIGNATURE Anne MacRae	

Product Line

author: [author] email: [email]

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BUREAU V. 8

SEP 13 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13 Film G20L 9-26-56 et

Reg. Dist. No.

09059

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN TB <u>35 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 610 Upland Rd.</u>		d. STREET ADDRESS <u>610 Upland Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> <u>Henery</u> <u>Earwaker</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>New Zealand</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Sophia Clark</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> <u>none</u>	
16. SOCIAL SECURITY NO. <u>705-05-6639</u>		17. INFORMANT <u>Mr. Charles Devese</u> , Address <u>Pikesville, Md. 611 Upland Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal Cell Cancer of Rt. ear</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at home <input type="checkbox"/> While <input type="checkbox"/> on street <input type="checkbox"/> While <input type="checkbox"/> in vehicle <input type="checkbox"/> While <input type="checkbox"/> in water <input type="checkbox"/> While <input type="checkbox"/> in fire <input type="checkbox"/> While <input type="checkbox"/> in other place <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		DATE SIGNED <u>9-11-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 13, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>SEP 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newells</u>	

RECEIVED

SEP 14 1956

BUREAU V. 1

TO HOSPITAL

may be returned

TO FUNERAL

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

by the hospital or attending physician.

REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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t. No.

9073

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>121 Overbrook Rd.</u>		d. STREET ADDRESS <u>121 Overbrook Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>A. F.</u> Last <u>EDWARDS</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1918</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lloyd Edwards</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Dietrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Chas. H. Underwood</u>	
17. INFORMATION <u>Chas. H. Underwood</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic arthritis spine</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month <u>Nov.</u> Day <u>2</u> Year <u>1949</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 2, 1949</u> to <u>Sept. 15, 1956</u> , that I last saw the deceased alive on <u>Sept. 14, 1956</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. V. Harbold</u>		DATE SIGNED <u>9/17/56</u>	
PHYSICIAN'S NAME (Type) <u>H. V. HARBOLD</u>		<u>Baltimore-14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		24a. REC'D BY REGISTRAR <u>SEP 18 1956</u>	
ADDRESS <u>1217 St. Paul St.</u>		24b. REGISTRAR'S SIGNATURE <u>Hubert Gray</u>	

STATE OF MARYLAND—DEPARTMENT OF HEALTH—BALTIMORE 18

SEP 18 1956

RECEIVED

9979

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. LENGTH OF STAY IN 1b <u>73yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>West Liberty Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Luke E. Ensor</u>		4. DATE OF DEATH <u>September 15, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1882</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canningsfactory</u>	
11. BIRTHPLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Noah E. Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Anna Foust</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>163-24-950</u>	
17. INFORMANT <u>Mrs. Luke Ensor, White Hall, Md.</u>		Address <u>White Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Liver (metastatic)</u> DUE TO <u>157x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Pancreas</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3-4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Sept. 15, 1956</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>56</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Fulton</u> M.D.		ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u> DATE SIGNED <u>9-17-56</u>	
PHYSICIAN'S NAME (Type) <u>W</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 18, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Hartington</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>9/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Date of registration		12. Place of registration	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9030 CERTIFICATE OF DEATH

09062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY BALTIMORE STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 S. ROLLING ROAD				d. STREET ADDRESS 105 S. ROLLING ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE ELIZABETH EVERSMEIER				4. DATE OF DEATH Month Day Year SEPT 6 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 20, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME FREDERICK KOPP				14. MOTHER'S MAIDEN NAME ANNIE E WERNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MRS GEORGE KLEMM, CATONSVILLE Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease DUE TO (b) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 422.1 DUE TO (c) 422.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis INTERVAL BETWEEN ONSET AND DEATH 3 YRS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1 , 19 53 to 9-4 , 19 56 that I last saw the deceased alive on 9-4 , 19 56 , and that death occurred at 9 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burgtorf M.D.				ADDRESS (Street, city or town, state) Ellcott City, Md			
DATE SIGNED 9-8-56							
PHYSICIAN'S NAME (Type) GEORGE E. BURGTORF							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-10-1956		22c. NAME OF CEMETERY OR CREMATORY GOOD SHEPHERD		22d. LOCATION (City, town, or county) (State) ELLKOTT CITY Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. CHIGIN BOTHOM ADDRESS ELLKOTT CITY, Md				24. REC'D BY REGISTRAR SEP 11 1956		24b. REGISTRAR'S SIGNATURE J. L. Barry	

RECEIVED

SEP 11 1956

BUREAU V. S.

CERTIFICATE OF DEATH

RECORD

MAINTAIN STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1956

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09063

9081

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 41 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MATILDA Middle FALK Last				4. DATE OF DEATH Month SEPTEMBER Day 25 Year 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HEN FRANK				14. MOTHER'S MAIDEN NAME STELLA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address CHART SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic and cardiovascular disease DUE TO (c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from AUG. 15 , 19 56 , to SEPT 25 , 19 56 , that I last saw the deceased alive on SEPT. 25 , 19 56 , and that death occurred at 5:55 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-26-56							
ACTUAL SIGNATURE <i>Charles S. Ward</i> M.D.							
PHYSICIAN'S NAME (Type) Charles S. Ward, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 9/28/56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.				24a. REC'D BY REGISTRAR SEP 27 1956		24b. REGISTRAR'S SIGNATURE <i>F. E. Harry</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
...		
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION		DATE OF DEATH		PLACE OF DEATH	
...		

BUREAU V. 1

SEP 27 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 155 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 6100 Walther Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle FIAMINGO Last FIAMINGO				4. DATE OF DEATH Month September Day 10 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1921		9. AGE (In years last birthday) yrs. 35	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Army Chemical Center		11. BIRTHPLACE (State or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Fiamingo				14. MOTHER'S MAIDEN NAME Maria Casale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> WW II		16. SOCIAL SECURITY NO. 091-12-2847		17. INFORMANT Clin. Rec., Vet. Administration Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE INFARCTION OF RIGHT FRONTAL LOBE DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation: Craniotomy with ligation of right anterior cerebral artery for aneurysm. 4/25/56						INTERVAL BETWEEN ONSET AND DEATH 52 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1956 , to September 10, 1956 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) FORT HOWARD, MARYLAND DATE SIGNED 9/10/56							
ACTUAL SIGNATURE Donald D. Mark				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/13/56		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5005 Harford Rd. Baltimore, Md.		24a. REC'D BY REGISTRAR SEP 13 1956	
				24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

Leonard J. Ruck Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09065

9083

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) <input checked="" type="checkbox"/>			
a. COUNTY <u>Baltimore</u>		MARYLAND		a. STATE <u>Maryland</u>		b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 3 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3403 Charles Court (Childs)</u>		3701.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>Fairfield 26, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marlene</u> Middle <u>Fields</u> Last <u>Fields</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27th</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/29/49</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George F. Fields</u>		14. MOTHER'S MAIDEN NAME <u>Martha Quickley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe emaciation</u>							
DUE TO							
(c) <u>Old tuberculous meningitis with severe brain damage</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/9</u> , 19 <u>55</u> , to <u>9/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/27</u> , 19 <u>56</u> , and that death occurred at <u>2:12 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Rich. Lindenberg (Pathol.)</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Richard Lindenberg, Pathologist</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline + Son's Reisterstown</u>				24a. REC'D BY REGISTRAR <u>9-29-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1956

BUREAU V. 5

OCT 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09066

9084

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b Dundalk 53			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Edgemere School				d. STREET ADDRESS 207 Patapsco Ave.			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle L Last FISHER				4. DATE OF DEATH Month Sept. Day 4 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1905	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry E. Fisher				14. MOTHER'S MAIDEN NAME Hattie L. Perkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Address Harry E. Fisher 207 Patapsco Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 min.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/6/56	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 7, 1956	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Colgate, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR SEP 10 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Farber	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

9035

CERTIFICATE OF DEATH

09067

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balt. City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>10 days</i>		d. STREET ADDRESS <i>3520 Hiltan Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Foley</i> Last <i>Foley</i>		4. DATE OF DEATH Month <i>9</i> Day <i>4</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 3, 1875</i>
9. AGE (In years last birthday) <i>81 1/2</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Ireland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Hugh Foley</i>	
14. MOTHER'S MAIDEN NAME <i>unknown Mary Thornton</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT Address <i>Records: SPRING GROVE STATE HOSPITAL</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Congestive heart failure</i> DUE TO (b) <i>Myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>-</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sep 3</i> , 19 <i>56</i> , to <i>Sep 4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sep 4</i> , 19 <i>56</i> , and that death occurred at <i>12:20 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William F. Clark</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>SEP 6 1956</i>	
PHYSICIAN'S NAME (Type) <i>William Frederick Clark</i>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/6/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Balt St.</i>		24a. REC'D BY REGISTRAR <i>SEP 6 1956</i> 24b. REGISTRAR'S SIGNATURE <i>V. E. Harry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		RACE		COLOR	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		CITY	
COUNTRY OF ENTRY		RACE		COLOR	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
COUNTRY OF BIRTH		RACE		COLOR	
DATE OF ENTRY INTO STATE		PLACE OF ENTRY		CITY	
COUNTRY OF ENTRY		RACE		COLOR	

RECEIVED
SEP 6 1956
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09068

9086

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND	STATE <u>MD</u> COUNTY <u>BALTIMORE</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>OVERLEA</u>	LENGTH OF STAY (in this place) <u>45 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4201 PRAGUE AVE</u>	STREET ADDRESS (If rural give location) <u>4201 PRAGUE AVE</u>		
3. NAME OF DECEASED: (First) <u>CHARLES</u> (Middle) <u>W.</u> (Last) <u>FOWLER</u>	4. DATE (Month) (Day) (Year) OF DEATH: <u>SEPT 5 1956</u>		
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>MAR. 20 1879</u>
9. AGE last birthday <u>77</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAKINIST</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>EDGEWOOD ARSENAL</u>	11. BIRTHPLACE (State or foreign country): <u>BALTIMORE MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>CHARLES FOWLER</u>		14. MOTHER'S MAIDEN NAME: <u>DELIA ESPY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT & ADDRESS: <u>CHARLES FOWLER 4201 PRAGUE AVE BALTO 6.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			<u>5 minutes</u>
DUE TO			
ANTECEDENT CAUSE (B) <u>Cardio-Vascular Hypertensive Disease</u>			<u>10 yrs.</u>
DUE TO			
(C) <u>Atherosclerosis</u>			<u>10 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 1951, to <u>Sept 5</u> , 1956, that I last saw the deceased alive on <u>Sept. 3</u> , 1956, and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Michael J. Dausch</u>		ADDRESS <u>M. D. 4636 Belair Road</u>	
DATE SIGNED <u>9/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>SEPT 8-56</u>	NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	LOCATION (City, town, or county) (State) <u>BELAIR RD BALTO MD</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS <u>Duffel Bros 7110 Belair Rd</u>

George Washington
Carlin - Virginia - Washington
October 10/90

Michael J. Brown
June 21 1890
2/6/90

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09069

9087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 10, 11, 13, 14, 17 FilmG204 9-28-56 et

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 906 Hooper Avenue				d. STREET ADDRESS 906 Hooper Avenue			
3. NAME OF DECEASED (Type or print) First ALMA Middle B. Last FRANK				4. DATE OF DEATH Month 9 Day 24 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Louis Furman				14. MOTHER'S MAIDEN NAME Rachel --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Norma Frank- as in item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-56		22c. NAME OF CEMETERY OR CREMATORY Herring Run		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc. 2100 Eutaw Pl., Balto., Md.				24a. REC'D BY REGISTRAR SEP 27 1956		24b. REGISTRAR'S SIGNATURE Dr. H. M. Luffey	

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

INSURANCE

ENTREV. TACCOB. 302

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SECRETION OF SECRETORY

BUREAU V. S.

SEP 28 1956

RECEIVED

• C. M. •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9088
CERTIFICATE OF DEATH

09070
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oliver Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS #3 Eyring Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles M. Franklin		4. DATE OF DEATH Month Sept. Day 14th Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18-1882
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months 10 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silversmith		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel G. Franklin		14. MOTHER'S MAIDEN NAME Julia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-8907	
17. INFORMANT Andrew J. Franklin		Address Beach 218 Chesapeake Ave. Oliver	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to Sept 14 , 19 56 , that I last saw the deceased alive on Sept 14 , 19 56 , and that death occurred at 6:55 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James F. White M.D. 422 Eastern Ave, Baltimore 21, Md 9/15/56 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 17th 56	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Taylor Ave. Balto Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly		ADDRESS 418 Eastern Blvd. Essex	
24a. REC'D BY REGISTRAR SEP 17 1956		24b. REGISTRAR'S SIGNATURE Harley	

BUREAU V. 3

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9089

CERTIFICATE OF DEATH

09071

Reg. Dist. No.

43

1. PLACE OF DEATH o. COUNTY Bato. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 38 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Madeline Ave.				d. STREET ADDRESS 22 Madeline Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Freeman				4. DATE OF DEATH Month 9 Day 20 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1880		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY own business		11. BIRTHPLACE (State or foreign country) Balto. City Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Freeman				14. MOTHER'S MAIDEN NAME Nancy Whiteley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-22-7748		17. INFORMANT Address Madeline Ave Mrs William Freeman 22 Madeline Ave 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Hypertensive Disease DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1956 to Sept. 20, 1956 , that I last saw the deceased alive on Sept. 20, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Michael J. Dausch M.D.				ADDRESS (Street, city or town, state) 4636 Belair Road		DATE SIGNED 9/21/56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/24/56		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd. 6		24a. REC'D BY REGISTRAR SEP 24 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. L. L. Kefferding			

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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BUREAU V. B.

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9090

CERTIFICATE OF DEATH

09072

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 82 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION No. 1 Beaumont Ave.				d. STREET ADDRESS No. 1 Beaumont Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM FREUND				4. DATE OF DEATH Month Day Year Sept. 21, 1956 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jacob Freund				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-8795		17. INFORMANT Address Mrs. Louise Freund 1 Beaumont Ave. Catons. 28			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 30 minutes 3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19 52 , to Sept 21 , 19 56 , that I last saw the deceased alive on Sept 21 , 19 56 , and that death occurred at 7:00 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Nesbitt Jr.				ADDRESS (Street, city or town, state) 1108 St. Paul St. Baltimore 3, Md.			
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR.				DATE SIGNED 9-24-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Caton				ADDRESS Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE 9/24/56	
				24b. REGISTRAR'S SIGNATURE Victor E. Harry			

BUREAU V. S.

SEP 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9091
CERTIFICATE OF DEATH
09073

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	c. LENGTH OF STAY IN 1b 43 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin 22x-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS ---	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle A. Last GADIES		4. DATE OF DEATH Month September Day 28 Year 19 56		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1895	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.	IF UNDER 24 HRS. Months 61 Days 61 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Truck Farming	11. BIRTHPLACE (State or foreign country) Tyaskin, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Eleven Gadies		
14. MOTHER'S MAIDEN NAME Ardilla MN: Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I		
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RIGHT LUNG 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Pyloric ulcer with penetration into pancreas		2. Diabetes mellitus		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. 19		
20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		
21. I certify that I attended the deceased from August 16, 1956 , to September 28, 1956 . That death occurred on September 28, 1956 , at 6:55 A.M. , from the causes and on the date stated above. Irving Freeman ADDRESS (Street, city or town, state) VETERANS ADMINISTRATION HOSPITAL DATE SIGNED 9/28/56				
ACTUAL SIGNATURE IRVING FREEMAN, M.D.				
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. FORT HOWARD, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-1-56	22c. NAME OF CEMETERY OR CREMATORY Tyaskin Cemetery	22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison, Balto. 1, Md. C.G. Messick Funeral Home, Bivalve, Maryland				
24a. REC'D. BY REGISTRAR 2 1956				24b. REGISTRAR'S SIGNATURE Lawson L. Fickley

RECEIVED

OCT 2 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09074	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 44	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>					c. LENGTH OF STAY IN lb <u>32 Hrs 40 Min.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>					d. STREET ADDRESS <u>1117 E. Pratt Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CEPHAS</u> Middle <u>A.</u> Last <u>GARBER</u>					4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>19 56</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/9/00</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Mt. Airy, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>Charles E. Garber</u>					14. MOTHER'S MAIDEN NAME <u>Florence Brippeon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-II</u>					16. SOCIAL SECURITY NO. <u>Unknown</u>					17. INFORMANT Address <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9045 FRACTURE OF SKULL - ACCIDENTAL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9045</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell and struck head</u>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/27</u> 1956 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>(Baltimore) Street by police.</u>	
20f. (City or town) <u>Baltimore</u>					20g. (County) <u>Unionville, Maryland</u>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Jack C Collins</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>9-30-56</u>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>10-1-56</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Linganore Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Unionville, Maryland</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook - Blight, Jr</u> 6009 Harford Rd. Baltimore, Md.					24a. REC'D BY REGISTRAR DATE <u>8</u> 1956					24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

32

BUREAU V. 1

OCT 8 1956

RECEIVED

9293

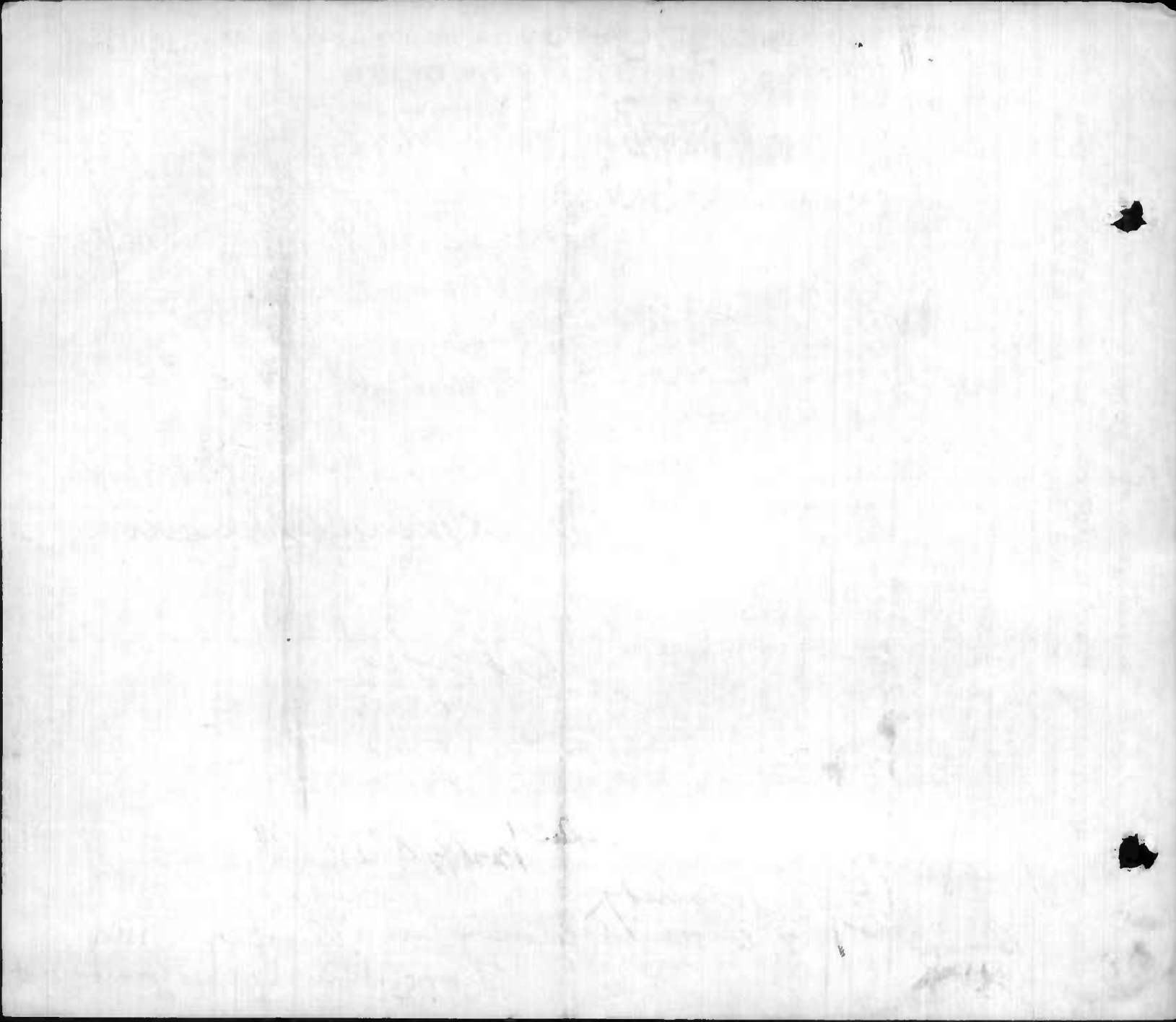
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> <u>Holothrop</u> <u>MARYLAND</u>				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Holothrop</u> <u>Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cuddled Nursing Home</u> <u>1960</u>				STREET ADDRESS (If rural give location) <u>No other address known</u> <u>119 1/2 North 111 1/2 Ave.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Martha</u> <u>H</u> <u>Garner</u>				<u>9</u> <u>2</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negro</u>	<u>WIDOWED</u>	<u>Nov. 31</u>	<u>103</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>				13. FATHER'S NAME: <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME: <u>Harvey</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT & ADDRESS: <u>Rev. Joseph Garner - 1227 5th St. Phila</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO <u>422.1</u> <u>Cardiovascular Disease</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old age</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1</u> , 1953 to <u>Aug 28</u> , 1956 that I last saw the deceased alive on <u>Aug 28</u> , 1956, and that death occurred at <u>12:20 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. M. Wilson</u>				DATE SIGNED <u>Sept 2 - 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-6-56</u>		<u>Int. Calvary Cem.</u>		<u>Brooklyn Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Chas. A. Wilson</u>		<u>601 W. Lombard St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9094

CERTIFICATE OF DEATH

09076 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Villa Maria b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson		c. LENGTH OF STAY IN 1b 4 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson		d. STREET ADDRESS Glenarm Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Maria Glenarm Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Mary Dilecta Garrett		4. DATE OF DEATH September 18 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1876
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Garrett		14. MOTHER'S MAIDEN NAME Annie Black	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sr. Mary Clara Notch Cliff Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arterio sclerotic cardio renal DUE TO (c) vascular disease INTERVAL BETWEEN ONSET AND DEATH 10 hours 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1952 , to Sept. 18 1956 , that I last saw the deceased alive on May 8 1956 , and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell 7501 York Rd. Towson, 4. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-20-56	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Zeller		24a. REC'D BY REGISTRAR SEP 20 1956	
ADDRESS 901 S. CONKLING ST. BALTO., 74, MD		24b. REGISTRAR'S SIGNATURE Mabel Gray	

STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Place of Birth		Date of Birth	
John Doe		New York		Jan 1, 1900	
Sex		Race		Color	
Male		White		White	
Marital Status		Occupation		Education	
Married		Farmer		High School	
Cause of Death		Manner of Death		Place of Death	
Heart Disease		Natural		Home	
Time of Death		Date of Death		Signature of Examiner	
10:00 AM		Jan 15, 1956		[Signature]	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 3

SEP 26 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG204 9-27-56 et

09078

9036

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus 27</u> c. LENGTH OF STAY IN b <u>6 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus 27 Maryland</u> d. STREET ADDRESS <u>1221 Seven Oaks Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PHILLIP</u> Middle <u>GOSZKA</u> Last <u>GOSZKA</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>21</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>night watchman</u>		<u>Cleveland Ohio</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cleveland Ohio</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Goszka</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>26-0593N</u>	
17. INFORMANT <u>Mrs Elizabeth Goszka</u>		Address <u>1221 Seven Oaks Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 COMPLETE HEART BLOCK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY SCLEROSIS</u> DUE TO (c) <u>ARTERIO-SCLEROTIC CARDIOVASC-RENAL DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APR. 7</u> , 19 <u>56</u> , to <u>SEPT. 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>SEPT. 20</u> , 19 <u>56</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry D. Knipp</u> M.D.		ADDRESS (Street, city or town, state) <u>4116-Edmondson Ave. Balto. 29 Md.</u>	
PHYSICIAN'S NAME (Type) <u>HARRY D. KNIPP M.D.</u>		DATE SIGNED <u>9/22/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Removal Sept 24-56</u>		<u>Newbridge Cem</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Newbridge Cem</u>		<u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Smith</u>		ADDRESS <u>1016 Carroll Ave SE</u>	
24a. REC'D BY REGISTRAR <u>SEP 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. M. Knipp</u>	

CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the certificate form, including fields for name, date, and cause of death.]

BUREAU V. S.

SEP 24 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

9996

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 30 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 204 Winters Lane	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE E. GRANGER		4. DATE OF DEATH Month Day Year 9 - 25 - 1956	
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY gen.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Columbus Nugent	
14. MOTHER'S MAIDEN NAME Harriett Nugent		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 212-32-1964		17. INFORMANT Mrs. Edna Ryan, Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Hypertension and Diabetes. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 68 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-18-56 , 19____, to 9-25-56 , 19____, that I last saw the deceased alive on 9-25-56 , 19____, and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 511 N. Schroeder St. Balto. Maryland DATE SIGNED 9-25-56			
ACTUAL SIGNATURE James S. Julian, Jr. M.D.		PHYSICIAN'S NAME (Type) James S. Julian, Jr. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-29-1956	22c. NAME OF CEMETERY White Rock	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR SEP 27 1956	24b. REGISTRAR'S SIGNATURE F. E. Harry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 9997 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

090897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CASSANDRA Middle E. Last HAMILTON				4. DATE OF DEATH Month Sept. Day 13 Year 1956			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1865	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Charles Henry Miller				14. MOTHER'S MAIDEN NAME Isabel Biscoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Julia E. Clark-441 E. Lorraine Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c) 903.0 Fracture of femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.0 Fracture of femur							
INTERVAL BETWEEN ONSET AND DEATH							
CERTIFICATION APPROVED BY [Signature] M. D. CHIEF OR ASST. MEDICAL EXAMINER							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home in bath room					
20c. TIME OF INJURY Month, Day, Year 4 Hour a. p. June 8 19 56 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) 441 E Lorraine Ave - Balto 18 Md	
21. I certify that I attended the deceased from 20 Apr. 1951 to 13 Sept. 1956 , that I last saw the deceased alive on 13 Sept. 1956 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William G. Helfrich				DATE SIGNED 5006 Roland Ave - Balto 10-9-56			
PHYSICIAN'S NAME (Type) William G. Helfrich				ADDRESS 5006 Roland Avenue - Balto. 10, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md. (BPO)				24a. REC'D BY REGISTRAR SEP 17 1956			
				24b. REGISTRAR'S SIGNATURE [Signature]			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF CORONER</p>		<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESSES</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF WITNESSES</p>	
<p>21. SIGNATURE OF REGISTRAR</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF WITNESSES</p>		<p>24. SIGNATURE OF REGISTRAR</p>		<p>25. SIGNATURE OF DECEASED</p>	
<p>26. SIGNATURE OF WITNESSES</p>		<p>27. SIGNATURE OF REGISTRAR</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF WITNESSES</p>		<p>30. SIGNATURE OF REGISTRAR</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESSES</p>		<p>33. SIGNATURE OF REGISTRAR</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF WITNESSES</p>	
<p>36. SIGNATURE OF REGISTRAR</p>		<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESSES</p>		<p>39. SIGNATURE OF REGISTRAR</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF WITNESSES</p>		<p>42. SIGNATURE OF REGISTRAR</p>		<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF WITNESSES</p>		<p>45. SIGNATURE OF REGISTRAR</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESSES</p>		<p>48. SIGNATURE OF REGISTRAR</p>		<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF WITNESSES</p>	
<p>51. SIGNATURE OF REGISTRAR</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF WITNESSES</p>		<p>54. SIGNATURE OF REGISTRAR</p>		<p>55. SIGNATURE OF DECEASED</p>	
<p>56. SIGNATURE OF WITNESSES</p>		<p>57. SIGNATURE OF REGISTRAR</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF WITNESSES</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESSES</p>		<p>63. SIGNATURE OF REGISTRAR</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF WITNESSES</p>	
<p>66. SIGNATURE OF REGISTRAR</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF WITNESSES</p>		<p>69. SIGNATURE OF REGISTRAR</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF WITNESSES</p>		<p>72. SIGNATURE OF REGISTRAR</p>		<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF WITNESSES</p>		<p>75. SIGNATURE OF REGISTRAR</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESSES</p>		<p>78. SIGNATURE OF REGISTRAR</p>		<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF WITNESSES</p>	
<p>81. SIGNATURE OF REGISTRAR</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF WITNESSES</p>		<p>84. SIGNATURE OF REGISTRAR</p>		<p>85. SIGNATURE OF DECEASED</p>	
<p>86. SIGNATURE OF WITNESSES</p>		<p>87. SIGNATURE OF REGISTRAR</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF WITNESSES</p>		<p>90. SIGNATURE OF REGISTRAR</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESSES</p>		<p>93. SIGNATURE OF REGISTRAR</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF WITNESSES</p>	
<p>96. SIGNATURE OF REGISTRAR</p>		<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESSES</p>		<p>99. SIGNATURE OF REGISTRAR</p>		<p>100. SIGNATURE OF DECEASED</p>	

RECEIVED
SEP 18 1956
BUREAU V. S.

9998

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. LENGTH OF STAY IN IB 1yr4mt27dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Hanlon Last Hanlon		4. DATE OF DEATH Month September Day 26 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? Ireland		13. FATHER'S NAME Peter Reville	
14. MOTHER'S MAIDEN NAME Elizabeth Donohue		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 29, 1955 to Sept. 26, 1956 , that I last saw the deceased alive on Sept. 26, 1956 , and that death occurred at 7:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-27-56	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9/29/56	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Wityke		24a. REC'D BY REGISTRAR DATE OCT 1 1956	
ADDRESS 401 Edmonson Ave.		24b. REGISTRAR'S SIGNATURE P. E. Harry	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9099

CERTIFICATE OF DEATH

09082

30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>M</u> Last <u>HARE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homework</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David. Rene man</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schultz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>720</u>	
17. INFORMANT <u>Spring Grove St. Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vasc. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - general-severe</u> DUE TO (c) <u>25 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene left foot</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/28</u> , 19 <u>56</u> , to <u>9/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>56</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachser</u>		DATE SIGNED <u>9/22/56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachser</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-25-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grave Room</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u>		ADDRESS <u>Hampstead, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>SEP 26 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>DR. J. H. SMITH</i>		11. SIGNATURE OF DECEASED <i>None</i>		12. SIGNATURE OF WITNESSES <i>None</i>	
13. SIGNATURE OF REGISTRAR <i>None</i>		14. SIGNATURE OF CLERK <i>None</i>		15. SIGNATURE OF CHIEF OF BUREAU <i>None</i>	

RECEIVED
BUREAU V. 2
SEP 26 1956

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

9100

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>632 Franklin Ave.</u>		d. STREET ADDRESS <u>632 Franklin Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Jenkins Hart</u>		4. DATE OF DEATH Month Day Year <u>September 24, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 7, 1903</u>
9. AGE (In years last birthday) yrs. <u>53</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Alice Lawton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218*01-6359</u>	
17. INFORMANT <u>Vernon Hart</u>		Address <u>632 Franklin ave. Balto. 21, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia, left base.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH. <u>7 months</u> <u>2 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 20, 1956</u> to <u>Sept 24, 1956</u> , that I last saw the deceased alive on <u>Sept 23, 1956</u> , and that death occurred at <u>9:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D.		ADDRESS (Street, city or town, state) <u>815 Eastern Ave</u> DATE SIGNED <u>9/25/56</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, MD.</u>		<u>Balt. 21, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Grynchuk</u>		24a. REC'D BY REGISTRAR DATE <u>9/25/56</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JANUARY 5, 1928	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		ATTORNEY AT LAW		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		4:00 PM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 5, 1968		APRIL 5, 1968		APRIL 5, 1968		APRIL 5, 1968	

BUREAU V. S.

SEP 29 1956

RECEIVED

9101

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Greenwood Ave.	
d. STREET ADDRESS 16 Greenwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle H. Last Hart		4. DATE OF DEATH Month Sept. Day 9, Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant-Retired		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis Hart		14. MOTHER'S MAIDEN NAME Eleanora Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-2814	
17. INFORMANT Maud E. Hart		Address 16 Greenwood Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8/9 , 19 56 to 10/5 , 19 56 , that I last saw the deceased alive on 8/9 , 19 56 , and that death occurred at 10:5 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John E. Gessner		ADDRESS (Street, city or town, state) 201 WISE AVE.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) John E. Gessner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 12, 1956	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Cosmopolitan Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR SEP 13 1956		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Ryaneider	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. NAME OF MOTHER		10. NAME OF FATHER		11. MARITAL STATUS		12. OCCUPATION		13. CAUSE OF DEATH		14. MANNER OF DEATH		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. DATE OF INTERVIEW		18. NAME OF INTERVIEWER		19. NAME OF WITNESS		20. NAME OF WITNESS		21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS	
25. NAME OF WITNESS		26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS		31. NAME OF WITNESS		32. NAME OF WITNESS	
33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS		36. NAME OF WITNESS		37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS		46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS	
49. NAME OF WITNESS		50. NAME OF WITNESS		51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS		56. NAME OF WITNESS	
57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS		61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS	
65. NAME OF WITNESS		66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS		71. NAME OF WITNESS		72. NAME OF WITNESS	
73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS		76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS		85. NAME OF WITNESS		86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS	
89. NAME OF WITNESS		90. NAME OF WITNESS		91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS		96. NAME OF WITNESS	
97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS		101. NAME OF WITNESS		102. NAME OF WITNESS		103. NAME OF WITNESS		104. NAME OF WITNESS	
105. NAME OF WITNESS		106. NAME OF WITNESS		107. NAME OF WITNESS		108. NAME OF WITNESS		109. NAME OF WITNESS		110. NAME OF WITNESS		111. NAME OF WITNESS		112. NAME OF WITNESS	
113. NAME OF WITNESS		114. NAME OF WITNESS		115. NAME OF WITNESS		116. NAME OF WITNESS		117. NAME OF WITNESS		118. NAME OF WITNESS		119. NAME OF WITNESS		120. NAME OF WITNESS	
121. NAME OF WITNESS		122. NAME OF WITNESS		123. NAME OF WITNESS		124. NAME OF WITNESS		125. NAME OF WITNESS		126. NAME OF WITNESS		127. NAME OF WITNESS		128. NAME OF WITNESS	
129. NAME OF WITNESS		130. NAME OF WITNESS		131. NAME OF WITNESS		132. NAME OF WITNESS		133. NAME OF WITNESS		134. NAME OF WITNESS		135. NAME OF WITNESS		136. NAME OF WITNESS	
137. NAME OF WITNESS		138. NAME OF WITNESS		139. NAME OF WITNESS		140. NAME OF WITNESS		141. NAME OF WITNESS		142. NAME OF WITNESS		143. NAME OF WITNESS		144. NAME OF WITNESS	
145. NAME OF WITNESS		146. NAME OF WITNESS		147. NAME OF WITNESS		148. NAME OF WITNESS		149. NAME OF WITNESS		150. NAME OF WITNESS		151. NAME OF WITNESS		152. NAME OF WITNESS	
153. NAME OF WITNESS		154. NAME OF WITNESS		155. NAME OF WITNESS		156. NAME OF WITNESS		157. NAME OF WITNESS		158. NAME OF WITNESS		159. NAME OF WITNESS		160. NAME OF WITNESS	
161. NAME OF WITNESS		162. NAME OF WITNESS		163. NAME OF WITNESS		164. NAME OF WITNESS		165. NAME OF WITNESS		166. NAME OF WITNESS		167. NAME OF WITNESS		168. NAME OF WITNESS	
169. NAME OF WITNESS		170. NAME OF WITNESS		171. NAME OF WITNESS		172. NAME OF WITNESS		173. NAME OF WITNESS		174. NAME OF WITNESS		175. NAME OF WITNESS		176. NAME OF WITNESS	
177. NAME OF WITNESS		178. NAME OF WITNESS		179. NAME OF WITNESS		180. NAME OF WITNESS		181. NAME OF WITNESS		182. NAME OF WITNESS		183. NAME OF WITNESS		184. NAME OF WITNESS	
185. NAME OF WITNESS		186. NAME OF WITNESS		187. NAME OF WITNESS		188. NAME OF WITNESS		189. NAME OF WITNESS		190. NAME OF WITNESS		191. NAME OF WITNESS		192. NAME OF WITNESS	
193. NAME OF WITNESS		194. NAME OF WITNESS		195. NAME OF WITNESS		196. NAME OF WITNESS		197. NAME OF WITNESS		198. NAME OF WITNESS		199. NAME OF WITNESS		200. NAME OF WITNESS	

BUREAU V. S.

SEP. 13 1956

RECEIVED

9937

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe c. LENGTH OF STAY IN 1b 1Wk d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5712 Mineral Ave.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn b. COUNTY Wilkes Barre c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilkes Barre d. STREET ADDRESS 58 Wyoming Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francis JOSEPH Haughney				4. DATE OF DEATH Sept. 1 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 3, 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD ENGINEER (RETIRED)				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) WILKES BARRE, PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MARTIN HAUGHNEY				14. MOTHER'S MAIDEN NAME MARGARET DAVIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.				16. SOCIAL SECURITY NO. 714-I2-1458		17. INFORMANT MBB. ELIZABETH W. HAUGHNEY (SAME AS #2d)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 9/5/56		22c. NAME OF CEMETERY OR CREMATORY MT. GREENWOOD	
22d. LOCATION (City, town, or county) (State) TRUCKSVILLE, PENNA.							
23. FUNERAL DIRECTOR'S SIGNATURE William J. Tickner + Sons				ADDRESS NORTH + PA. AVES		24a. REC'D BY REGISTRAR SEP 4 1956	
				24b. REGISTRAR'S SIGNATURE Dr. Geo. S. M. Kieffer			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 5 1956

BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9102

CERTIFICATE OF DEATH

Reg. Dist. No. 09080

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>36 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Shelby Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BERTHA I. HELM</u>		4. DATE OF DEATH <u>9/30/56</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas F. Mc Gill</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Harding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>8-100-10000</u>	
17. INFORMANT <u>Emory Helm (same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute coronary insufficiency</u> DUE TO (c) <u>arteriosclerotic hypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 1/2 hrs</u> <u>7 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>9-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-30</u> , 19 <u>56</u> , and that death occurred at <u>4:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u>		ADDRESS (Street, city or town, state) <u>1118 St. Paul St., Baltimore, 2, Maryland</u>	
DATE SIGNED <u>10-1-56</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nab + Son</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR <u>DATE 10-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>T.E. Hargy</u>	

BUREAU V. S.

1956 OCT 5

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09087

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney, Balto.				c. LENGTH OF STAY IN 1b Unk.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9206 Old Harford Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Michael Last Herman				4. DATE OF DEATH Month Sept. Day 22 , Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar., 10, 1921	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Herman				14. MOTHER'S MAIDEN NAME Sylvia Baseman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W. II				16. SOCIAL SECURITY NO.			
17. INFORMANT Wife				Address 9206 Old Harford Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --		20f. (City or town) (County) (State) -- --	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Frank T. Kasik, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank T. Kasik, Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-56		22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Seitz				ADDRESS 814 W 36 St		24a. REC'D BY REGISTRAR DATE 9/24/56	
				24b. REGISTRAR'S SIGNATURE Dr. H. McBarney			

MEDICAL CERTIFICATION

TO DEPUTY-MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate on a separate sheet, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 25 1956

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

47

9104

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tork-Hyde P.O.</u>		c. LENGTH OF STAY IN lb <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyde P.O.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sunshine Ave</u>				d. STREET ADDRESS <u>Sunshine Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick Alphonsus Hilmer</u>				4. DATE OF DEATH Month Day Year <u>Sept 19-11 1956</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 1 - 1868</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator Western U.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilhelm Hilmer</u>				14. MOTHER'S MAIDEN NAME <u>McKee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Frederick E. Hilmer - 74 Woodington Rd.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis Generalized</u> DUE TO (c) <u>Severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u> <u>Under-lying</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John C. Hyle</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept. 22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. B. Thickett</u>				ADDRESS <u>1300 Eastern Place</u>		24a. REC'D BY REGISTRAR <u>DATE 21 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS - CERTIFICATE OF DEATH

BUREAU V. 2

SEP 21 1956

RECEIVED

TO HOSPITAL-OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09090

9105

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ARMACOST NURSING HOME		d. STREET ADDRESS 3016 HAMILTON AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH L. HINES		4. DATE OF DEATH Month Day Year 9 23 19 56	
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1887
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VALENTINE BRANDAU		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT FRANK HINES, SR.		Address 3016 HAMILTON AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days 6 hrs 25 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10, 1956 , to Sept 23, 1956 , that I last saw the deceased alive on Sept 23, 1956 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Lechman		ADDRESS (Street, city or town, state) DATE SIGNED 2322 CALLOW AVE	
PHYSICIAN'S NAME (Type) HARRY LECHMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/26/56	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMT.		22d. LOCATION (City, town, or county) (State) BALTIMORE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE E.F. Hoffmann		ADDRESS 3218 HUDSON ST.	
24a. REC'D BY REGISTRAR 26 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

Reg. Dist. No.

44

9106

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard,</u>				c. LENGTH OF STAY IN IB <u>43 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>112 Montrose Avenue</u>							
3. NAME OF DECEASED (Type or print) First <u>MARTIN</u> Middle <u>(NMI)</u> Last <u>HITTEL</u>				4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/22/92</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>64</u> Days <u>64</u> Hours <u>64</u> Min. <u>64</u>		IF UNDER 24 HRS. Months <u>64</u> Days <u>64</u> Hours <u>64</u> Min. <u>64</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Martin Hittel</u>				14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>July 21</u> , 19 <u>56</u> , to <u>September 2</u> , 19 <u>56</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Veterans Administration Hospital</u> DATE SIGNED <u>9/3/56</u> ACTUAL SIGNATURE <u>Arthur G. Edwards</u> M.D. PHYSICIAN'S NAME (Type) <u>ARTHUR G. EDWARDS, M. D.</u> <u>Fort Howard, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight Inc., 6009 Harford Rd., Balto., Md.</u>				24. REC'D BY REGISTRAR <u>SEP 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Bailey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 5 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 TSM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										090930	
FOR APPROVAL BY MEDICAL EXAMINER CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Fusting Ave., (House in Pines)					d. STREET ADDRESS 2925 Winchester St.,					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle H. Last Homburg					4. DATE OF DEATH Month Sept. Day 25, Year 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 19, 1865		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant					10b. KIND OF BUSINESS OR INDUSTRY J.E. Hurst & Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Geo. Wm. A. Homburg					14. MOTHER'S MAIDEN NAME Anna C. Hachtel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Robert F. Gibson Address 2925 Winchester Ave.,				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & Occlusion 422.1 DUE TO Advanced arteriosclerotic cardiac vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 923.0 (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell in bedroom at home 7 Sept 56. Fracture, neck of right femur. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell on bedroom floor 5 AM at home. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year SEP 7 1956 Hour o. m. 5 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME 20f. (City or town) BALTIMORE (County) MARYLAND 21. I certify that I attended the deceased from 11 May , 19 55 , to 25 Sept , 19 56 , that I last saw the deceased alive on 23 Sept , 19 56 , and that death occurred at 6:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 601 Winans Way DATE SIGNED 26 Sept 56 ACTUAL PHYSICIAN Emil H. Henning Jr. M.D. Baltimore 29 Md PHYSICIAN'S NAME (Type) EMIL H HENNING JR M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-27-1956 22c. NAME OF CEMETERY OR CREMATORY Loudon Park 22d. LOCATION (City, town, or county) Baltimore (State) Md. 23. FUNERAL DIRECTOR'S SIGNATURE D. Howard Strong ADDRESS 3207 W. North Ave. 24. REC'D BY REGISTRAR SEP 26, 1956 24b. REGISTRAR'S SIGNATURE H. E. Harry											

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 3

SEP 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09093

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY HARFORD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS HARFORD AV.	
3. NAME OF DECEASED (Type or print) First DELMORE Middle RAMSAY Last HOPKINS		4. DATE OF DEATH Month SEPT. Day 6th Year 1956	
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/09
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOVEL OPR.		10b. KIND OF BUSINESS OR INDUSTRY MINING	
11. BIRTHPLACE (State or foreign country) BINDER, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBT. R. HOPKINS		14. MOTHER'S MAIDEN NAME INEZ LINCOLN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FIBROSIS OF LUNGS 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SILICOSIS DUE TO (c) his Occupation.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal growth			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-5 , 19 56 , to 9-6- , 19 56 , that I last saw the deceased alive on 9-6- , 19 56 , and that death occurred at 9:55 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson State Hospital DATE SIGNED 9-6-56			
ACTUAL SIGNATURE William Newcomer M.D.		DATE SIGNED 9-6-56	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Mt. Wilson State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-9-56	
22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Perkins		24a. REC'D BY REGISTRAR DATE 9-9-56	
ADDRESS Delta, Pa.		24b. REGISTRAR'S SIGNATURE Harold A. Murrell	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

HARTFORD

CARDIFF

HARTFORD AV

SEPT

HARTFORD

HARTFORD

HARTFORD

USA

HARTFORD

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9109

CERTIFICATE OF DEATH

09094

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 YORKLEIGH Rd.</u>				d. STREET ADDRESS <u>113 YORKLEIGH Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER ROGER HOPKINS</u>				4. DATE OF DEATH Month Day Year <u>Sept 7 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28 1909</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER</u>		11. BIRTHPLACE (State or foreign country) <u>TORONTO ONT. CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER R HOPKINS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE M.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-036687</u>		17. INFORMANT <u>Ruth Read Hopkins</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Sept 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 7</u> , 19 <u>56</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Allan Snier</u>				ADDRESS (Street, city or town, state) <u>4408 Loch Raven Blvd Baltimore 18 Maryland</u>			
DATE SIGNED _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hopkins</u>				ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>SEP 11 1956</u>	
				DATE _____		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09095

9110

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacoast Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. STREET ADDRESS 507 Dogwood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle BIBB Last HORNOR		4. DATE OF DEATH Month September Day 28 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1883
9. AGE (In years and birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Bibb	
14. MOTHER'S MAIDEN NAME Catherine Barlow		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Thomas Hornor, 507 Dogwood Lane, Towson 4, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal Hemorrhage DUE TO 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Carcinomatosis, abdomen DUE TO 18 mo (c) Adenocarcinoma, colon 18 mo		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 1955 to Sept 28, 1956 , that I last saw the deceased alive on Sept 28, 1956 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederick J. Vollmer		ADDRESS (Street, city or town, state) 6100 York Rd Baltimore, Md	
PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		DATE SIGNED Sept 29, 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Maryland	
24a. REC'D BY REGISTRAR Sept. 30, 1956		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 3

OCT 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9111

CERTIFICATE OF DEATH

09096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosewood Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3001-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>Dwings Mills, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Matie</u> Middle <u>Florence</u> Last <u>Horsley</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-20</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>36</u> Days <u>22</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward D. Horsley</u>		14. MOTHER'S MAIDEN NAME <u>Marie Theresa Schleich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Rosewood Records</u>	
17. INFORMANT Address <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and chronic pneumonia</u> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration of foreign material</u> DUE TO (c) <u>cerebral palsy with dysfunction of swallowing</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Megacolon</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/27</u> , 19 <u>36</u> , to <u>9/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Rich. Zinkov (Pathologist) M.D.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morland Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook - Blight Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF SHERIFF'S DEPUTY		21. SIGNATURE OF SHERIFF'S CLERK	
22. SIGNATURE OF SHERIFF'S CLERK		23. SIGNATURE OF SHERIFF'S CLERK		24. SIGNATURE OF SHERIFF'S CLERK	
25. SIGNATURE OF SHERIFF'S CLERK		26. SIGNATURE OF SHERIFF'S CLERK		27. SIGNATURE OF SHERIFF'S CLERK	
28. SIGNATURE OF SHERIFF'S CLERK		29. SIGNATURE OF SHERIFF'S CLERK		30. SIGNATURE OF SHERIFF'S CLERK	
31. SIGNATURE OF SHERIFF'S CLERK		32. SIGNATURE OF SHERIFF'S CLERK		33. SIGNATURE OF SHERIFF'S CLERK	
34. SIGNATURE OF SHERIFF'S CLERK		35. SIGNATURE OF SHERIFF'S CLERK		36. SIGNATURE OF SHERIFF'S CLERK	
37. SIGNATURE OF SHERIFF'S CLERK		38. SIGNATURE OF SHERIFF'S CLERK		39. SIGNATURE OF SHERIFF'S CLERK	
40. SIGNATURE OF SHERIFF'S CLERK		41. SIGNATURE OF SHERIFF'S CLERK		42. SIGNATURE OF SHERIFF'S CLERK	
43. SIGNATURE OF SHERIFF'S CLERK		44. SIGNATURE OF SHERIFF'S CLERK		45. SIGNATURE OF SHERIFF'S CLERK	
46. SIGNATURE OF SHERIFF'S CLERK		47. SIGNATURE OF SHERIFF'S CLERK		48. SIGNATURE OF SHERIFF'S CLERK	
49. SIGNATURE OF SHERIFF'S CLERK		50. SIGNATURE OF SHERIFF'S CLERK		51. SIGNATURE OF SHERIFF'S CLERK	
52. SIGNATURE OF SHERIFF'S CLERK		53. SIGNATURE OF SHERIFF'S CLERK		54. SIGNATURE OF SHERIFF'S CLERK	
55. SIGNATURE OF SHERIFF'S CLERK		56. SIGNATURE OF SHERIFF'S CLERK		57. SIGNATURE OF SHERIFF'S CLERK	
58. SIGNATURE OF SHERIFF'S CLERK		59. SIGNATURE OF SHERIFF'S CLERK		60. SIGNATURE OF SHERIFF'S CLERK	
61. SIGNATURE OF SHERIFF'S CLERK		62. SIGNATURE OF SHERIFF'S CLERK		63. SIGNATURE OF SHERIFF'S CLERK	
64. SIGNATURE OF SHERIFF'S CLERK		65. SIGNATURE OF SHERIFF'S CLERK		66. SIGNATURE OF SHERIFF'S CLERK	
67. SIGNATURE OF SHERIFF'S CLERK		68. SIGNATURE OF SHERIFF'S CLERK		69. SIGNATURE OF SHERIFF'S CLERK	
70. SIGNATURE OF SHERIFF'S CLERK		71. SIGNATURE OF SHERIFF'S CLERK		72. SIGNATURE OF SHERIFF'S CLERK	
73. SIGNATURE OF SHERIFF'S CLERK		74. SIGNATURE OF SHERIFF'S CLERK		75. SIGNATURE OF SHERIFF'S CLERK	
76. SIGNATURE OF SHERIFF'S CLERK		77. SIGNATURE OF SHERIFF'S CLERK		78. SIGNATURE OF SHERIFF'S CLERK	
79. SIGNATURE OF SHERIFF'S CLERK		80. SIGNATURE OF SHERIFF'S CLERK		81. SIGNATURE OF SHERIFF'S CLERK	
82. SIGNATURE OF SHERIFF'S CLERK		83. SIGNATURE OF SHERIFF'S CLERK		84. SIGNATURE OF SHERIFF'S CLERK	
85. SIGNATURE OF SHERIFF'S CLERK		86. SIGNATURE OF SHERIFF'S CLERK		87. SIGNATURE OF SHERIFF'S CLERK	
88. SIGNATURE OF SHERIFF'S CLERK		89. SIGNATURE OF SHERIFF'S CLERK		90. SIGNATURE OF SHERIFF'S CLERK	
91. SIGNATURE OF SHERIFF'S CLERK		92. SIGNATURE OF SHERIFF'S CLERK		93. SIGNATURE OF SHERIFF'S CLERK	
94. SIGNATURE OF SHERIFF'S CLERK		95. SIGNATURE OF SHERIFF'S CLERK		96. SIGNATURE OF SHERIFF'S CLERK	
97. SIGNATURE OF SHERIFF'S CLERK		98. SIGNATURE OF SHERIFF'S CLERK		99. SIGNATURE OF SHERIFF'S CLERK	
100. SIGNATURE OF SHERIFF'S CLERK		101. SIGNATURE OF SHERIFF'S CLERK		102. SIGNATURE OF SHERIFF'S CLERK	

BUREAU V. S.

OCT 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09097

CERTIFICATE OF DEATH

Reg. Dist. No.

9112

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe	
c. LENGTH OF STAY IN 1b 33 days		d. STREET ADDRESS None	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLIE Middle L Last HUMMER		4. DATE OF DEATH Month September Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/6/19
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Trappe, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Hummer		14. MOTHER'S MAIDEN NAME Dora Blades	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 218-07-8914	
17. INFORMANT Clin.Div. Vets.Adminis.Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBOPHLEBITIS AXILLARY AND SUBCLAVIAN VEIN, RIGHT DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATELY 3 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATIC HEART DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6, 1956 , to September 8, 1956 , that he was the deceased alive on August 12, 1956 , and that death occurred at 11:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED ACTUAL SIGNATURE Caridad E. Gonzalez M.D. Fort Howard, Md. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-56	
22c. NAME OF CEMETERY OR CREMATORY Upper Bambury Cemetery		22d. LOCATION (City, town, or county) (State) Trappe, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel S. Bluff ADDRESS 6009 Harford Rd., Balto., Maryland		24b. REGISTRAR'S SIGNATURE Lawson L. Farley	

Picked up by: Newman & Son Funeral Dir., Easton, Maryland

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

SEP. 13 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG204 9-27-56 et

9038

CERTIFICATE OF DEATH

09098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 First Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Salvatore Iraci				4. DATE OF DEATH Month Sept. Day 20 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1888	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosp. Attendant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Joseph Iraci				14. MOTHER'S MAIDEN NAME Anna Clement			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Josephine Clements, 412 First Ave Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatous 154x DUE TO Carcinoma of Rectum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 months unknown						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1/4 , 19 56 , to 9/20 , 19 56 , that I last saw the deceased alive on 9/20 , 19 56 , and that death occurred at 10:52 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eliot W. Johnson M.D.				ADDRESS (Street, city or town, state) 8432 Frederick Ave DATE SIGNED 9/21/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.				24a. REC'D BY REGISTRAR SEP 24 1956		24b. REGISTRAR'S SIGNATURE Dr. Geo M. Kieffer	

CERTIFICATE OF DEATH

Reg. No. 201

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Manner of Death		Physician's Signature		Signature of Registrar	
[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]		[Faint text]	

BUREAU V. S.

SEP 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

9113

1. PLACE OF DEATH a. COUNTY BALTIMORE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TURNER'S STA. 22		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 Bethlehem Steel Co. Hospital			d. STREET ADDRESS 16 Woodland Ave. - 22		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Michael Middle Janowich Last S.R.			4. DATE OF DEATH Month Sept. Day 4 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 9 - 1917	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SKETCHING - SHEET METAL - SHIP BLDG.		10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME MAX SANDWICH			14. MOTHER'S MAIDEN NAME IDA WASELINKA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-07-7088		17. INFORMANT ELIZ. T. SANDWICH - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BALTO. CO. A.D.	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M.B. Davis			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) M. B. Davis, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-8-56		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN	
22d. LOCATION (City, town, or county) (State) BALTO. CO. A.D.		22e. REC'D BY REGISTRAR SEP 6 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Perley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		35		M		W		10-10-55		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
1000 W. BALTIMORE		LABORER		HEART DISEASE		NATURAL		HYPERTENSION		NO	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARRIAGE		SINGLE	
10-10-20		BALTIMORE, MD.		HIGH SCHOOL		CATHOLIC		MARRIED		YES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
10-10-55		BALTIMORE, MD.		HEART DISEASE		NATURAL		HYPERTENSION		NO	

BUREAU V. E.

SEP 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9114

CERTIFICATE OF DEATH

09100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7yr4mth23dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Urias Middle Last Johns				4. DATE OF DEATH Month Sept. Day 27, Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Urias Johns				14. MOTHER'S MAIDEN NAME Margaret Ludwig			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1913 -- 1916				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral gangrene of legs 451x DUE TO Thrombosis of lower aorta (b) DUE TO Arteriosclerotic aneurysm of the aorta (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 18 , 19 56 to Sept. 27 , 19 56 , that I last saw the deceased alive on Sept. 27 , 19 56 , and that death occurred at 10:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslor				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.				DATE SIGNED Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		10/1/56		BALTO. NATIONAL		BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE C.F. Hoffmann				ADDRESS 3218 Hudson St		24a. REC'D BY REGISTRAR DATE	
						24b. REGISTRAR'S SIGNATURE T. E. Harry	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 1-1

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES J. JONES		Male		35		1921		Maryland		1956		Baltimore		Heart Disease		Natural		J. J. Jones		J. J. Jones		10/2/56	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of death		24. Date of burial	
J. J. Jones		Son		1234 Main St.		Baltimore		Maryland		21201		123-4567		J. J. Jones		J. J. Jones		10/2/56		10/2/56		10/2/56	
25. Name of funeral home		26. Address		27. City		28. State		29. Zip		30. Telephone		31. Signature of funeral home		32. Signature of registrar		33. Date of registration		34. Date of death		35. Date of burial		36. Date of cremation	
J. J. Jones		1234 Main St.		Baltimore		Maryland		21201		123-4567		J. J. Jones		J. J. Jones		10/2/56		10/2/56		10/2/56		10/2/56	

BUREAU V. S.

OCT 2 1956

RECEIVED

9115

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Balto</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green Glen Arm</u>		c. LENGTH OF STAY IN 1b <u>9 mos</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES. ALLEN JOHNSON</u>		4. DATE OF DEATH <u>Sept. 1 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/20</u>
9. AGE (in years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DENNIS A JOHNSON Sr.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>218-18-1105</u>	
17. INFORMANT <u>Dennis A Johnson</u>		Address <u>2001 Oakington Ave Balto 11 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Cardiac Arrest - Strokes Adams</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis ?</u> DUE TO (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		DATE SIGNED <u>9/2/56</u>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK, JR.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-5-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McDowell Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore City Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank T. Seitz</u>		ADDRESS <u>814 W 36th St Balto 11 Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please re-execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-COMMISSIONER
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 6 1956
BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09102

9116

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE-19</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>817 I St.</u>		d. STREET ADDRESS <u>#1</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN CORNELIUS JOHNSON</u>		4. DATE OF DEATH <u>SEPT 3 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17. 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mill</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Emanuel Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Polly Dowden</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>213-07-8654</u>		17. INFORMANT <u>Lillian Mae Johnson (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial failure</u> (c) <u>sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>56</u> , to <u>Sept 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 3</u> , 19 <u>56</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Torkin</u>		M.D. <u>6908 N. Point Rd</u> <u>9/3/56</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TORKIN</u>		<u>Balto. 19 - Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-6-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arboretum</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel M. Sullivan</u>		ADDRESS <u>Balto. 19 - Md.</u>	
24a. RECEIVED BY REGISTRAR <u>SEP 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence L. Larky</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES C. BROWN		45		M		W		1911		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
MARRIED		1935		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
EDUCATION		SCHOOL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
OCCUPATION		BUSINESS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
BUSINESS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
CAUSE OF DEATH		HEART		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HEART		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
MANNER OF DEATH		NATURAL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
NATURAL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
DATE OF DEATH		1956		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
PLACE OF DEATH		HOME		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HOME		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF PHYSICIAN		JAMES C. BROWN		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
JAMES C. BROWN		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	
SIGNATURE OF REGISTRAR		JAMES C. BROWN		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
JAMES C. BROWN		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD.	

BUREAU V. S.

SEP 5 1956

RECEIVED

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09103

Reg. Dist. No.

9117

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>4 yrs 1 mo 24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr. School</u>				d. STREET ADDRESS <u>Mapleville</u> 104-2			
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Arthur</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/37</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Wellington Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Catherine Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Institution Records</u> Address <u>Owings Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration with diarrhea.</u> 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Electrolyte imbalance due to diarrhea</u> DUE TO (c) <u>Spastic myoglobinuria.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept 24</u> , 19 <u>56</u> , to <u>Sept 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 29</u> , 19 <u>56</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George C. Medairy</u>				DATE SIGNED <u>Rosewood State Training School</u>			
PHYSICIAN'S NAME (Type) <u>Dr. George C. Medairy</u>				ADDRESS <u>Owings Mills, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-2-1956</u>		<u>Green Ch. B. Cemetery</u>		<u>Mapleville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladden</u>				ADDRESS <u>Ch. Middletown, Md.</u>		24. REC'D BY REGISTRAR DATE <u>3 Oct, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>			

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

11

BUREAU V. S.

OCT

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09104

9731

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. LENGTH OF STAY IN 1b <u>15 YRS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22, MD.</u>				53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2813 DUNGLIN CT.</u>				d. STREET ADDRESS <u>2813 DUNGLIN COURT</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>KIDD</u> Last <u>KEENER</u>				4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>56</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 11, 1912</u>	
9. AGE (In years lost birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>THOMAS KIDD</u>				14. MOTHER'S MAIDEN NAME <u>JNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WALTER A KEENER</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1951</u> to <u>Sept 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 11</u> , 19 <u>56</u> , and that death occurred at <u>8:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Mackowiak</u> M.D.				ADDRESS (Street, city or town, state) <u>6714 Holabrook Ave</u>			
PHYSICIAN'S NAME (Type) <u>S. C. MACKOWIAK</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>9-17-56</u>		<u>UNION</u>		<u>WEATHERLY, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley, Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. P. Kelly</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

RECEIVED
 SEP 17 1956
 BUREAU V. S.

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Sept 11 1956</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Thrombosis</i>		ORGAN OR PART AFFECTED <i>Heart</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
DATE OF SIGNATURE <i>Sept 11 1956</i>		DATE OF SIGNATURE <i>Sept 11 1956</i>		DATE OF SIGNATURE <i>Sept 11 1956</i>		DATE OF SIGNATURE <i>Sept 11 1956</i>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 FilmG204 9-21-56 et

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9118

CERTIFICATE OF DEATH

09105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>MARYLAND</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONVILLE</i> c. LENGTH OF STAY IN 1b <i>1 month</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i> d. STREET ADDRESS <i>1606 WILKENS AVE</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNIE M. KITZ MILLER</i>		4. DATE OF DEATH Month Day Year <i>Sept. 13 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-30-1876</i> 9. AGE (In years last birthday) yrs. <i>79</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
13. FATHER'S NAME <i>JOHN H. BEAKLEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>-</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>MR. HARRY M. KITZ MILLER</i> Address <i>1606 WILKENS AVE</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crown Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Crown Arteriosclerosis</i> (c) <i>Aged</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>unknown</i> <i>11</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 11</i> , 19 <i>56</i> to <i>Sept 13</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept 11</i> , 19 <i>56</i> , and that death occurred at <i>7:15 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4605 EDMONDSON AVE</i> DATE SIGNED <i>9/14/56</i> ACTUAL SIGNATURE <i>Cliff Ratliff Jr.</i> M.D. PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF, JR.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept 17, 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Boonsboro Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Boonsboro Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Truman Schaub</i> ADDRESS <i>3512 Frederick Ave.</i>		24a. REC'D BY REGISTRAR <i>SEP 17 1956</i>	24b. REGISTRAR'S SIGNATURE <i>V. C. Harry</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BATHING OF 10

CERTIFICATE OF DEATH

BUREAU A. 5

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09106

9119

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 187 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First STEPHEN Middle (NMI) Last KONSKI				4. DATE OF DEATH Month SEPTEMBER Day 13, Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-90	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SWEEPER		10b. KIND OF BUSINESS OR INDUSTRY B & O RAILROAD		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELL KONSKI				14. MOTHER'S MAIDEN NAME MICHALINA WONSOSKI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> WW-1		16. SOCIAL SECURITY NO. 705-09-6514		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163x DUE TO ASSOCIATED WITH PULMONARY TUBERCULOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 19 56 to Sept. 13, 19 56 , and that death occurred at 4:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Q. Arce				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland		DATE SIGNED 9-13-56	
PHYSICIAN'S NAME (Type) S. Q. ARCE				M.D. VAH, Fort Howard, Maryland		9-13-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-17-56	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski, 2007 Eastern Ave., Balto. 31, Md.				24a. REC'D BY REGISTRAR SEP 17		24b. REGISTRAR'S SIGNATURE Dewey L. Larky	

BUROAU A. S.

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

9120

2411 N. Charles Street, Baltimore

09107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
TOWN <u>4600 Ridgeway Ave</u>		TOWN <u>4600 Ridgeway Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Louise T. Krass</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 8 1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 2 1876</u> 9. AGE last birthday <u>80 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Can. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Zaranek</u>		14. MOTHER'S MAIDEN NAME <u>Topila Hudika</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>220-24-7473</u>	
17. INFORMANT AND ADDRESS <u>Sofia Anzulowicz 4600 Ridgeway</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>CORONARY ARTERIOSCLEROSIS</u>		<u>2 yrs</u>
Antecedent cause(s) (b) <u>Generalized Arteriosclerosis with Hypertension</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1951, to Sept 8, 1956 that I last saw the deceased alive on Sept 7, 1956, and that death occurred at 5: P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8-10-56

H.W. Hildner

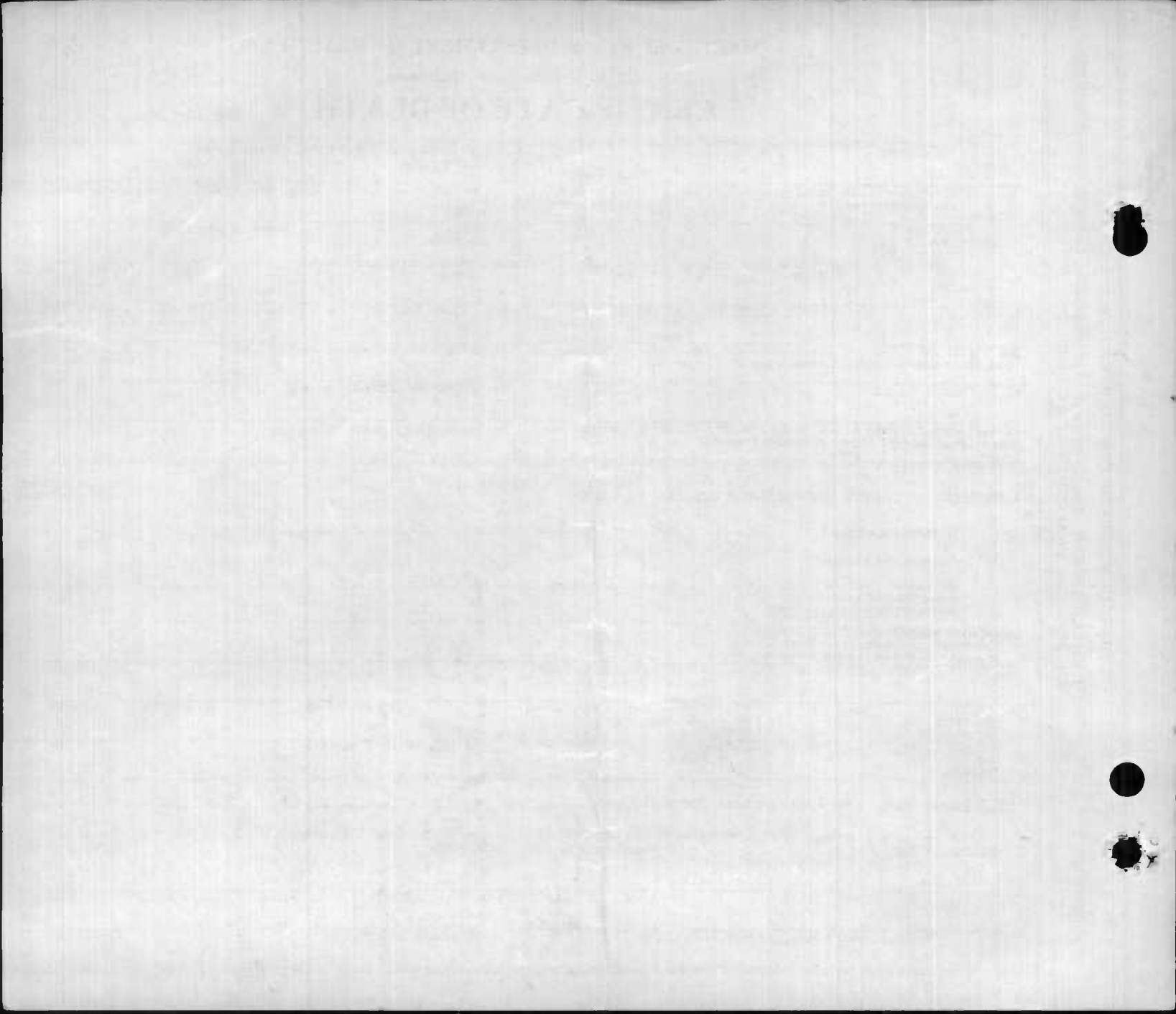
82

7110 BELAIR RD

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09108

9121

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 23 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 4015 Penhurst Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD M. LEACH		4. DATE OF DEATH Month Day Year September 19 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1878
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Sales	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Leach		14. MOTHER'S MAIDEN NAME Frances Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SAW		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA - Duration Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 27, 1956 , to September 19, 1956 , when he died. and that death occurred at 1:30 A.M. from the causes and on the date stated above. and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis G. Dickey M.D. VETERANS ADMINISTRATION HOSPITAL 9/19/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, Chief, Medical Service FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-24-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner North & Penna. Aves. Baltimore, Maryland		24a. REGISTRAR'S SIGNATURE Sanson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

932

CERTIFICATE OF DEATH

09109

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2906 Dunmurry Road		d. STREET ADDRESS 2906 Dunmurry Road	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle A. Last Le BRUN		4. DATE OF DEATH Month Sept. Day 6 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH June 11, 1890	9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Florist	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph Le Brun		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Emma Ludwig		17. INFORMANT Mrs. Johanna Le Brun 2906 Dunmurry Road-22	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. No.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Fibrosis DUE TO (c) Nephrosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteomyelitis Chronic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-6 to 9-6 , 19 56 , that I last saw the deceased alive on 9-6 , 19 56 , and that death occurred at 437 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Collins		DATE SIGNED 9-6-56	
PHYSICIAN'S NAME (Type) JACK Collins		Baltimore 22	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1956	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 24. P. Kelly	
ADDRESS 2112 Dundalk Ave.		DATE SEP 10 1956	

BUREAU V. S.

SEP 10 1956

RECEIVED

9122

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville 28				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. STREET ADDRESS 275 Mc Curley St.			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Lee				4. DATE OF DEATH Month September Day 17 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter helper				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John H. Lee				14. MOTHER'S MAIDEN NAME Mary Jane Dyles PYLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 2-19-12-7285		17. INFORMANT Mrs. Catherine Jones (sister)		Address 275 Mc Curley St. Baltimore 29, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11, 1956 , to Sept. 17, 1956 , that I last saw the deceased alive on Sept. 17, 1956 , and that death occurred at 8:00 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-17-56			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/19/56		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chester Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chester town		24a. REC'D BY REGISTRAR SEP 19 1956	
				24b. REGISTRAR'S SIGNATURE V. E. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2-1-1955

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH JANUARY 5, 1928		PLACE OF BIRTH MOBILE, ALABAMA	
MARRIAGE MARRIED		OCCUPATION CONGRESSIONAL SECRETARY		EDUCATION HIGH SCHOOL	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH MEMPHIS, TENNESSEE	
DATE OF DEATH APRIL 4, 1968		TIME OF DEATH 2:01 PM		PLACE OF DEATH MEMPHIS, TENNESSEE	
SEX MALE		AGE 40		RACE WHITE	
RELIGION METHODIST		MARITAL STATUS MARRIED		OCCUPATION CONGRESSIONAL SECRETARY	
EDUCATION HIGH SCHOOL		PLACE OF BIRTH MOBILE, ALABAMA		DATE OF BIRTH JANUARY 5, 1928	
NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH JANUARY 5, 1928		PLACE OF BIRTH MOBILE, ALABAMA	
MARRIAGE MARRIED		OCCUPATION CONGRESSIONAL SECRETARY		EDUCATION HIGH SCHOOL	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH MEMPHIS, TENNESSEE	
DATE OF DEATH APRIL 4, 1968		TIME OF DEATH 2:01 PM		PLACE OF DEATH MEMPHIS, TENNESSEE	
SEX MALE		AGE 40		RACE WHITE	
RELIGION METHODIST		MARITAL STATUS MARRIED		OCCUPATION CONGRESSIONAL SECRETARY	
EDUCATION HIGH SCHOOL		PLACE OF BIRTH MOBILE, ALABAMA		DATE OF BIRTH JANUARY 5, 1928	

BUREAU V. 8

SEP 19 1956

RECEIVED

9123

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River		c. LENGTH OF STAY IN 1b 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 924 Wampler Rd.		d. STREET ADDRESS 924 Wampler Rd.	
3. NAME OF DECEASED (Type or print) First Herman Middle Mairose Last Mairose		4. DATE OF DEATH Month Sept. Day 3 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1866
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Walker		10b. KIND OF BUSINESS OR INDUSTRY P. R. R.	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown Mairose	
14. MOTHER'S MAIDEN NAME Unknown Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Walter T. Mairose 936 Wampler Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 ds 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 19 56 , to Sept 3 , 19 56 , that I last saw the deceased alive on Sept 3 , 19 56 , and that death occurred at 6 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George Baumgardner M.D.		DATE SIGNED 9/4/56	
PHYSICIAN'S NAME (Type) George Baumgardner		ADDRESS (Street, city or town, state) Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 6, 1956	22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24. REC'D BY REGISTRAR SEP 5 1956	
ADDRESS 7401 Belair Rd		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director may be released by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 5 1956

BUREAU V.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9124

CERTIFICATE OF DEATH

0911338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 78 yrs				c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 18 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home				d. STREET ADDRESS 3900 Greenway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle JOSEPHINE Last MALCHOW				4. DATE OF DEATH Month Sept. Day 28 Year 1956 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June. 21. 1875		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY 0 - - -		11. BIRTHPLACE (State or foreign country) New York City.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Otto Malchow				14. MOTHER'S MAIDEN NAME Meta Huner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. K none		17. INFORMANT Miss Grace Malchow		Address 3900 Greenway	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia, Right Lung, Hypostatic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept. 23, 1956 , to Sept. 28, 1956 , that I last saw the deceased alive on Sept. 28, 1956 , and that death occurred at 1:35 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Loy M. Zimmerman M.D.				ADDRESS (Street, city or town, state) 3202 Hartford Rd.		DATE SIGNED Sept. 29, 1956	
PHYSICIAN'S NAME (Type) Loy M. Zimmerman				BALTIMORE - 18, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.				ADDRESS Baltimore Md.		24a. REC'D BY REGISTRAR 2 1956	
24b. REGISTRAR'S SIGNATURE Michael Gray							

CERTIFICATE OF DEATH

1934

NAME OF DECEASED JOSEPHINE MADONNA		AGE 48 years		SEX Female		RACE White		DATE OF BIRTH June 21, 1886		PLACE OF BIRTH New York City	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart failure		PERIOD OF ILLNESS 2 weeks		PLACE OF DEATH Home		DATE OF DEATH October 2, 1934		PLACE OF DEATH New York City	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME St. Mary's		NAME OF BURIAL PLACE St. Mary's		NAME OF CEMETERY St. Mary's		NAME OF CITY New York City		NAME OF STATE New York	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF FUNERAL HOME St. Mary's		NAME OF BURIAL PLACE St. Mary's		NAME OF CEMETERY St. Mary's		NAME OF CITY New York City		NAME OF STATE New York	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF FUNERAL HOME St. Mary's		NAME OF BURIAL PLACE St. Mary's		NAME OF CEMETERY St. Mary's		NAME OF CITY New York City		NAME OF STATE New York	

BUREAU V. 1

OCT 2 1934

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

Reg. Dist. No. 38

9125

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,		c. LENGTH OF STAY IN 1b 4days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Amos Last Matthews		4. DATE OF DEATH Month Sept. Day 17 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-1872
9. AGE in years last birthday 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner-manager		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eli Matthews	
14. MOTHER'S MAIDEN NAME Sara Price		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Lucy Ensor, Monkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept 12, 1956 , to Sept 17, 1956 , that I last saw the deceased alive on Sept 16, 1956 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. France		ADDRESS (Street, city or town, state) Parlton, Md.	
PHYSICIAN'S NAME (Type) A. M. FRANCE		DATE SIGNED 9/17/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-19-56	22c. NAME OF CEMETERY OR CREMATORY Clymmalira Methodist	22d. LOCATION (City, town, or county) (State) Monkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		ADDRESS Sparks, Md.	24a. REC'D BY REGISTRAR Sept. 20, 1956
		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1-1-1912		Maryland		Baltimore		Heart Disease		1-15-1956		10:00 AM		Home		Natural		J. A. Smith		M. B. Jones	

BUREAU V. 1

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9126

CERTIFICATE OF DEATH

0911530
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daniel A. McKenna		4. DATE OF DEATH Month Day Year September 14, 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1877
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairyman		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John McKenna		14. MOTHER'S MAIDEN NAME Margaret O'Brien	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO unknown		16. SOCIAL SECURITY NO. 215-10-2377	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22, 1956 , to Sept. 14, 1956 , that I last saw the deceased alive on Sept. 14, 1956 , and that death occurred at 3:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED 9-14-56	
PHYSICIAN'S NAME (Type) Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery,		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon J. Lamm		24a. REC'D BY REGISTRAR SEP 17 1956	
ADDRESS 4611 Park Heights		24b. REGISTRAR'S SIGNATURE V. E. Harris	

BUREAU V. 1

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09116

9127

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE-GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 6 1/2 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRENTWOOD	
3. NAME OF DECEASED (Type or print) First IDA Middle PEARL Last MCMICHAEL		4. DATE OF DEATH Month SEPTEMBER Day 3 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/1892
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY fun home	
11. BIRTHPLACE (State or foreign country) ALBANY, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES NEWELL		14. MOTHER'S MAIDEN NAME DELIA NEWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO (b) Far advanced with cavitation DUE TO (c) 7 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 56 , to 9/12 , 19 56 , that I last saw the deceased alive on 9/1 , 19 56 , and that death occurred at 12:04 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 7 1956	
		24b. REGISTRAR'S SIGNATURE Donathy Newell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09117

31

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3725 Patterson Avenue		d. STREET ADDRESS 3725 Patterson Avenue	
3. NAME OF DECEASED (Type or print) First LOUIS Middle THOMAS Last MEISER, III		4. DATE OF DEATH Month Sept. Day 30 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1944
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months 12 Days 12	IF UNDER 24 HRS. Hours 12 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? Baltimore, Md.	
13. FATHER'S NAME Louis Thomas, Meiser, Jr.		14. MOTHER'S MAIDEN NAME Edith Elizabeth Meiser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Louis T. Meiser, Jr - 3725 Patterson Ave.	
17. INFORMANT Meiser		Address Louis T. Meiser, Jr - 3725 Patterson Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to ligature compression of neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 925.0 (c) Asphyxiated while playing with a rope DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asphyxiated while playing with a rope			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Asphyxiated while playing with a rope	
20c. TIME OF INJURY Month, Day, Year 4:15 a.m. 9/30 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		DATE SIGNED 10/1/56	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/1956	
22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost - 4600 Liberty Hgts. Ave.		ADDRESS 4600 Liberty Hgts. Ave.	
24a. REC'D BY REGISTRAR Oct 2, 1956		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

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BUREAU V.

OCT 3 1956

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RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 44

9129

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>9 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>634 W. Biddle Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>(NMI)</u> Last <u>MIONER</u>				4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/90</u>	
9. AGE (In years last birthday) <u>66 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Stanton, Va.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fish Market</u>		11. BIRTHPLACE (State or foreign country) <u>Stanton, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jim Mioner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Vone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> DUE TO <u>UNKNOWN</u> (c) <u>UNKNOWN</u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TBC FAR ADVANCED BILATERAL ARRESTED</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 5</u> , 19 <u>56</u> , to <u>Sept. 14</u> , 19 <u>56</u> , that I saw the deceased live and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard C. Kramer</u> M.D.				ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>9/15/56</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD C. KRAMER, M.D.</u>				VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-19-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Farber</u>				ADDRESS <u>400 Madison Ave. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept. 24-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Howard C. Kramer</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

9561-88

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09119

9130

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1816 East 32nd Street			
3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last MOORE				4. DATE OF DEATH Month September Day 13 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 26, 1896	
9. AGE (In years last birthday) 60 yrs.		10. KIND OF BUSINESS OR INDUSTRY Transportation - Army Maintenance		11. BIRTHPLACE (State or foreign country) Gloucester Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Lee Moore				14. MOTHER'S MAIDEN NAME Harriet L. Dulton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 220-05-2246		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE 420.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 8, 1956 , to September 13, 1956 , and that death occurred at 4:35 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND 9/13/56							
ACTUAL SIGNATURE Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND 9/13/56							
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home				ADDRESS 2601 Madison (E) Balto., Md.		24a. REC'D BY REGISTRAR P 14 1956	
				24b. REGISTRAR'S SIGNATURE Dawson L. Farley			

BUREAU V. S.

SEP 14 1956

RECEIVED

9131

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>129 Cedarmere Road</u>				d. STREET ADDRESS <u>129 Cedarmere Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>WHITE</u> Last <u>MORISON</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Morison</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry W. Morison</u> Address <u>129 Cedarmere Rd Owings Mills</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 28, 1955</u> , to <u>September 12, 1956</u> , that I last saw the deceased alive on <u>May 15, 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u>				ADDRESS (Street, city or town, state) <u>Kesterstown Maryland</u> DATE SIGNED <u>Sept 12, 1956</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2</u>				24a. REC'D BY REGISTRAR <u>SEP 17 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 15

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1891	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Teacher		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. DATE OF DEATH 1956		10. TIME OF DEATH 10:00 AM		11. PLACE OF DEATH Home		12. SIGNATURE OF DECEASED (None)	
13. SIGNATURE OF PHYSICIAN J. H. Smith		14. SIGNATURE OF WITNESS J. H. Smith		15. SIGNATURE OF REGISTRAR J. H. Smith		16. SIGNATURE OF CLERK J. H. Smith	
17. SIGNATURE OF DECEASED (None)		18. SIGNATURE OF WITNESS (None)		19. SIGNATURE OF REGISTRAR (None)		20. SIGNATURE OF CLERK (None)	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF WITNESS (None)		23. SIGNATURE OF REGISTRAR (None)		24. SIGNATURE OF CLERK (None)	
25. SIGNATURE OF DECEASED (None)		26. SIGNATURE OF WITNESS (None)		27. SIGNATURE OF REGISTRAR (None)		28. SIGNATURE OF CLERK (None)	
29. SIGNATURE OF DECEASED (None)		30. SIGNATURE OF WITNESS (None)		31. SIGNATURE OF REGISTRAR (None)		32. SIGNATURE OF CLERK (None)	
33. SIGNATURE OF DECEASED (None)		34. SIGNATURE OF WITNESS (None)		35. SIGNATURE OF REGISTRAR (None)		36. SIGNATURE OF CLERK (None)	
37. SIGNATURE OF DECEASED (None)		38. SIGNATURE OF WITNESS (None)		39. SIGNATURE OF REGISTRAR (None)		40. SIGNATURE OF CLERK (None)	
41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF WITNESS (None)		43. SIGNATURE OF REGISTRAR (None)		44. SIGNATURE OF CLERK (None)	
45. SIGNATURE OF DECEASED (None)		46. SIGNATURE OF WITNESS (None)		47. SIGNATURE OF REGISTRAR (None)		48. SIGNATURE OF CLERK (None)	
49. SIGNATURE OF DECEASED (None)		50. SIGNATURE OF WITNESS (None)		51. SIGNATURE OF REGISTRAR (None)		52. SIGNATURE OF CLERK (None)	
53. SIGNATURE OF DECEASED (None)		54. SIGNATURE OF WITNESS (None)		55. SIGNATURE OF REGISTRAR (None)		56. SIGNATURE OF CLERK (None)	
57. SIGNATURE OF DECEASED (None)		58. SIGNATURE OF WITNESS (None)		59. SIGNATURE OF REGISTRAR (None)		60. SIGNATURE OF CLERK (None)	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF WITNESS (None)		63. SIGNATURE OF REGISTRAR (None)		64. SIGNATURE OF CLERK (None)	
65. SIGNATURE OF DECEASED (None)		66. SIGNATURE OF WITNESS (None)		67. SIGNATURE OF REGISTRAR (None)		68. SIGNATURE OF CLERK (None)	
69. SIGNATURE OF DECEASED (None)		70. SIGNATURE OF WITNESS (None)		71. SIGNATURE OF REGISTRAR (None)		72. SIGNATURE OF CLERK (None)	
73. SIGNATURE OF DECEASED (None)		74. SIGNATURE OF WITNESS (None)		75. SIGNATURE OF REGISTRAR (None)		76. SIGNATURE OF CLERK (None)	
77. SIGNATURE OF DECEASED (None)		78. SIGNATURE OF WITNESS (None)		79. SIGNATURE OF REGISTRAR (None)		80. SIGNATURE OF CLERK (None)	
81. SIGNATURE OF DECEASED (None)		82. SIGNATURE OF WITNESS (None)		83. SIGNATURE OF REGISTRAR (None)		84. SIGNATURE OF CLERK (None)	
85. SIGNATURE OF DECEASED (None)		86. SIGNATURE OF WITNESS (None)		87. SIGNATURE OF REGISTRAR (None)		88. SIGNATURE OF CLERK (None)	
89. SIGNATURE OF DECEASED (None)		90. SIGNATURE OF WITNESS (None)		91. SIGNATURE OF REGISTRAR (None)		92. SIGNATURE OF CLERK (None)	
93. SIGNATURE OF DECEASED (None)		94. SIGNATURE OF WITNESS (None)		95. SIGNATURE OF REGISTRAR (None)		96. SIGNATURE OF CLERK (None)	
97. SIGNATURE OF DECEASED (None)		98. SIGNATURE OF WITNESS (None)		99. SIGNATURE OF REGISTRAR (None)		100. SIGNATURE OF CLERK (None)	

RECEIVED
SEP 17 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09121

9132

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fork		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bottom Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard A. Mullan		4. DATE OF DEATH Month Sept. Day 12, Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1906
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Post Office		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard A. Mullan		14. MOTHER'S MAIDEN NAME Eva Cornthworite	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W. # 2 None	
17. INFORMANT Elizabeth A. Mullan		Address Bottom Rd. Hyde, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of rectum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 154X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 1955 to Sept 9, 1956 , that I last saw the deceased alive on Sept. 10, 1956 , and that death occurred at 9:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William G. Tyson M.D.		ADDRESS (Street, city or town, state) Kingsville Md. DATE SIGNED 9-13-56	
PHYSICIAN'S NAME (Type) William A. Tyson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Balto. U.S. National		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kearns Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR SEP 17 1956		24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15 1891</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>May 10 1915</i>	
9. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		10. NAME OF SPOUSE <i>Elizabeth A. Smith</i>	
11. DATE OF DEATH <i>Aug 10 1956</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		16. SIGNATURE OF REGISTRAR <i>John D. Smith</i>	
17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
19. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		20. SIGNATURE OF JURY <i>John D. Smith</i>	
21. SIGNATURE OF DECEASED <i>John A. Smith</i>		22. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
23. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		24. SIGNATURE OF JURY <i>John D. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
27. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		28. SIGNATURE OF JURY <i>John D. Smith</i>	
29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
31. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		32. SIGNATURE OF JURY <i>John D. Smith</i>	
33. SIGNATURE OF DECEASED <i>John A. Smith</i>		34. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
35. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		36. SIGNATURE OF JURY <i>John D. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
39. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		40. SIGNATURE OF JURY <i>John D. Smith</i>	
41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
43. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		44. SIGNATURE OF JURY <i>John D. Smith</i>	
45. SIGNATURE OF DECEASED <i>John A. Smith</i>		46. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
47. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		48. SIGNATURE OF JURY <i>John D. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
51. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		52. SIGNATURE OF JURY <i>John D. Smith</i>	
53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
55. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		56. SIGNATURE OF JURY <i>John D. Smith</i>	
57. SIGNATURE OF DECEASED <i>John A. Smith</i>		58. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
59. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		60. SIGNATURE OF JURY <i>John D. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
63. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		64. SIGNATURE OF JURY <i>John D. Smith</i>	
65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
67. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		68. SIGNATURE OF JURY <i>John D. Smith</i>	
69. SIGNATURE OF DECEASED <i>John A. Smith</i>		70. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
71. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		72. SIGNATURE OF JURY <i>John D. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
75. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		76. SIGNATURE OF JURY <i>John D. Smith</i>	
77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
79. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		80. SIGNATURE OF JURY <i>John D. Smith</i>	
81. SIGNATURE OF DECEASED <i>John A. Smith</i>		82. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
83. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		84. SIGNATURE OF JURY <i>John D. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
87. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		88. SIGNATURE OF JURY <i>John D. Smith</i>	
89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
91. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		92. SIGNATURE OF JURY <i>John D. Smith</i>	
93. SIGNATURE OF DECEASED <i>John A. Smith</i>		94. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
95. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		96. SIGNATURE OF JURY <i>John D. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF WITNESSES <i>Elizabeth A. Smith</i>	
99. SIGNATURE OF CLERGYMAN <i>Rev. J. H. Jones</i>		100. SIGNATURE OF JURY <i>John D. Smith</i>	

RECEIVED
SEP 17 1956
BUREAU V. 3

9133

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		d. STREET ADDRESS 1514 Ridge Road	
3. NAME OF DECEASED (Type or print) First DOTTIE Middle VIOLA Last MULLINIX		4. DATE OF DEATH Month September Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 2, 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Upton Mullinix	
14. MOTHER'S MAIDEN NAME Jane Wolfe		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mamie Jane Shank Address 107 Shadynook Court Catonsville 28, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS. DUE TO (c) AGEING.			INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 0 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT, 16 , 19 56 , to SEPT, 20 , 19 56 , that I last saw the deceased alive on SEPT, 19 , 19 56 , and that death occurred at 9:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Lloyd Johnson M.D.		ADDRESS (Street, city or town, state) 6348 FREDERICK ROAD DATE SIGNED	
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON M.D.		CATONSVILLE MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Howard Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Long Corner, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md. ADDRESS		24a. REC'D BY REGISTRAR DATE 9/21/56	24b. REGISTRAR'S SIGNATURE Victor E. Harry

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 24 1956

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BATHING 15

9134

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write name and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3701-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3505 Forest Park Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ISADORE</u> First <u>MYERBERG</u> Middle <u>Freida</u> Last		4. DATE OF DEATH <u>9-30-1956</u> Month <u>9</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Repair</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mayer</u>		14. MOTHER'S MAIDEN NAME <u>Freida</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Theresa Myerberg</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary of Sigmoid</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>coronary occlusion Dec. 1955</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 23, 1942</u> to <u>Sept 20, 1956</u> , that I last saw the deceased alive on <u>Sept 20, 1956</u> , and that death occurred at <u>530 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Whitehouse</u> M.D.		ADDRESS (Street, city or town, state) <u>2933 No Charles St</u> DATE SIGNED <u>10/1/56</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL WHITEHOUSE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-1-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>United Reform</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>DATE 10/2/1956</u>	24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1956

FILE NO.

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
J. J. J. J. J. J.		J. J. J. J. J. J.		J. J. J. J. J. J.	
SEX		RACE		EDUCATION	
Male		White		High School	
MARRIED		SINGLE		WIDOWED	
Married		Single		Widowed	
PLACE OF BIRTH		CITY OF RESIDENCE		CITY OF DEATH	
J. J. J. J. J. J.		J. J. J. J. J. J.		J. J. J. J. J. J.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
J. J. J. J. J. J.		J. J. J. J. J. J.		J. J. J. J. J. J.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED	
J. J. J. J. J. J.		J. J. J. J. J. J.		J. J. J. J. J. J.	

BUREAU V. S.

OCT 2 1956

RECEIVED

CERTIFICATE OF DEATH

09124 36

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridderwood		c. LENGTH OF STAY IN lb 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Broadway Road Sorenson Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUISE F. NALLEY		4. DATE OF DEATH Month Sept. Day 26, Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 6 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Lecker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Elizabeth L. McDonald-918 Radcliffe Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis chronic with failure 442 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Toxaemia renal DUE TO (c) Possible renal damage INTERVAL BETWEEN ONSET AND DEATH gradual 10 days 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury	
20c. TIME OF INJURY Month, Day, Year Hour o. n. none 19 p. m. none		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from July 31 , 19 56 , to Sept. 26 , 19 56 , that I last saw the deceased alive on September 22 , 19 56 , and that death occurred at 7.50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 516 Cathedral Street Balto. I Md. DATE SIGNED 9-26-56			
ACTUAL SIGNATURE James Graham Marston		M.D. 516 Cathedral Street Balto. I Md.	
PHYSICIAN'S NAME (Type) James Graham Marston		516 Cathedral Street Balto. I Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/56	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md. (B.P.B.)		24a. REC'D BY REGISTRAR 1 OCT 1 1956	
24b. REGISTRAR'S SIGNATURE Mabel L...			

HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0132

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH MEMPHIS, TENNESSEE		6. COUNTY SHELBY		7. STATE TENNESSEE		8. CITY MEMPHIS	
9. OCCUPATION Attorney		10. MARITAL STATUS Single		11. RACE White		12. RELIGION Methodist	
13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. ICD-9 CODE 430.0		16. UIC CODE 01	
17. SIGNATURE OF PHYSICIAN J. Edgar Hoover		18. SIGNATURE OF REGISTRAR J. Edgar Hoover		19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF DECEASED J. Edgar Hoover	
21. DATE OF SIGNATURE April 4, 1968		22. PLACE OF SIGNATURE Baltimore, MD		23. SIGNATURE OF DECEASED J. Edgar Hoover		24. SIGNATURE OF WITNESS J. Edgar Hoover	
25. DATE OF SIGNATURE April 4, 1968		26. PLACE OF SIGNATURE Baltimore, MD		27. SIGNATURE OF DECEASED J. Edgar Hoover		28. SIGNATURE OF WITNESS J. Edgar Hoover	
29. DATE OF SIGNATURE April 4, 1968		30. PLACE OF SIGNATURE Baltimore, MD		31. SIGNATURE OF DECEASED J. Edgar Hoover		32. SIGNATURE OF WITNESS J. Edgar Hoover	
33. DATE OF SIGNATURE April 4, 1968		34. PLACE OF SIGNATURE Baltimore, MD		35. SIGNATURE OF DECEASED J. Edgar Hoover		36. SIGNATURE OF WITNESS J. Edgar Hoover	
37. DATE OF SIGNATURE April 4, 1968		38. PLACE OF SIGNATURE Baltimore, MD		39. SIGNATURE OF DECEASED J. Edgar Hoover		40. SIGNATURE OF WITNESS J. Edgar Hoover	
41. DATE OF SIGNATURE April 4, 1968		42. PLACE OF SIGNATURE Baltimore, MD		43. SIGNATURE OF DECEASED J. Edgar Hoover		44. SIGNATURE OF WITNESS J. Edgar Hoover	
45. DATE OF SIGNATURE April 4, 1968		46. PLACE OF SIGNATURE Baltimore, MD		47. SIGNATURE OF DECEASED J. Edgar Hoover		48. SIGNATURE OF WITNESS J. Edgar Hoover	
49. DATE OF SIGNATURE April 4, 1968		50. PLACE OF SIGNATURE Baltimore, MD		51. SIGNATURE OF DECEASED J. Edgar Hoover		52. SIGNATURE OF WITNESS J. Edgar Hoover	
53. DATE OF SIGNATURE April 4, 1968		54. PLACE OF SIGNATURE Baltimore, MD		55. SIGNATURE OF DECEASED J. Edgar Hoover		56. SIGNATURE OF WITNESS J. Edgar Hoover	
57. DATE OF SIGNATURE April 4, 1968		58. PLACE OF SIGNATURE Baltimore, MD		59. SIGNATURE OF DECEASED J. Edgar Hoover		60. SIGNATURE OF WITNESS J. Edgar Hoover	
61. DATE OF SIGNATURE April 4, 1968		62. PLACE OF SIGNATURE Baltimore, MD		63. SIGNATURE OF DECEASED J. Edgar Hoover		64. SIGNATURE OF WITNESS J. Edgar Hoover	
65. DATE OF SIGNATURE April 4, 1968		66. PLACE OF SIGNATURE Baltimore, MD		67. SIGNATURE OF DECEASED J. Edgar Hoover		68. SIGNATURE OF WITNESS J. Edgar Hoover	
69. DATE OF SIGNATURE April 4, 1968		70. PLACE OF SIGNATURE Baltimore, MD		71. SIGNATURE OF DECEASED J. Edgar Hoover		72. SIGNATURE OF WITNESS J. Edgar Hoover	
73. DATE OF SIGNATURE April 4, 1968		74. PLACE OF SIGNATURE Baltimore, MD		75. SIGNATURE OF DECEASED J. Edgar Hoover		76. SIGNATURE OF WITNESS J. Edgar Hoover	
77. DATE OF SIGNATURE April 4, 1968		78. PLACE OF SIGNATURE Baltimore, MD		79. SIGNATURE OF DECEASED J. Edgar Hoover		80. SIGNATURE OF WITNESS J. Edgar Hoover	
81. DATE OF SIGNATURE April 4, 1968		82. PLACE OF SIGNATURE Baltimore, MD		83. SIGNATURE OF DECEASED J. Edgar Hoover		84. SIGNATURE OF WITNESS J. Edgar Hoover	
85. DATE OF SIGNATURE April 4, 1968		86. PLACE OF SIGNATURE Baltimore, MD		87. SIGNATURE OF DECEASED J. Edgar Hoover		88. SIGNATURE OF WITNESS J. Edgar Hoover	
89. DATE OF SIGNATURE April 4, 1968		90. PLACE OF SIGNATURE Baltimore, MD		91. SIGNATURE OF DECEASED J. Edgar Hoover		92. SIGNATURE OF WITNESS J. Edgar Hoover	
93. DATE OF SIGNATURE April 4, 1968		94. PLACE OF SIGNATURE Baltimore, MD		95. SIGNATURE OF DECEASED J. Edgar Hoover		96. SIGNATURE OF WITNESS J. Edgar Hoover	
97. DATE OF SIGNATURE April 4, 1968		98. PLACE OF SIGNATURE Baltimore, MD		99. SIGNATURE OF DECEASED J. Edgar Hoover		100. SIGNATURE OF WITNESS J. Edgar Hoover	

BUREAU V. S.

OCT 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09125

CERTIFICATE OF DEATH

Reg. Dist. No.

38

9136

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Connsdie</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>600 Woodbine Terrace</i>	
3. NAME OF DECEASED (Type or print) <i>Alice M. Norris</i>		4. DATE OF DEATH <i>Sept. 2nd</i> 19 <i>56</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 3rd 1894</i>
9. AGE (In years, last birthday) <i>62</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dept Store</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Wilbert Christopher</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Dunaway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-22-7137</i>	
17. INFORMANT <i>Mrs. Brooks</i>		Address <i>600 Woodbine Ter.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage -</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio-Vascular Disease</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterial Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>4 June</i> , 19 <i>56</i> , to <i>2 Sept</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1 Sept</i> , 19 <i>56</i> , and that death occurred at <i>1317</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William Wilbert</i> M.D.		ADDRESS (Street, city or town, state) <i>5006 Roland Ave</i> DATE SIGNED <i>Sept 3 '56</i>	
PHYSICIAN'S NAME (Type) <i>Balto 10, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/4/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lebon Cemetery</i>		22d. LOCATION (City, town, or county) <i>Kelmar nook Va.</i> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Inc</i> ADDRESS <i>1217 St. Paul st. Balto, Md</i>		24. REC'D BY REGISTRAR <i>SEP 4 1956</i> 24b. REGISTRAR'S SIGNATURE <i>Thelma Gray</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER		DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	

BUREAU V. S.

SEP 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09126₃₀

9137

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mths18dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle L. Last Norris		4. DATE OF DEATH Month Sept. Day 25, Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1881
9. AGE (In years lost birthday) 74? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile brain disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6, 19 56 to Sept. 25, 19 56 , that I last saw the deceased alive on Sept. 25, 19 56 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 9-25-56 ACTUAL SIGNATURE Charles Ward M.D. PHYSICIAN'S NAME (Type) Charles S. Ward, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE 5005 Hill Rd. Baltimore, Md.		24. REC'D BY REGISTRAR SEP 1 1956	
25. REGISTRAR'S SIGNATURE J. C. Harris		26. REGISTRAR'S SIGNATURE	

9138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upper Marlborough</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hosp.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Zephria E NORTON</i>		4. DATE OF DEATH Month <i>9</i> Day <i>29</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/16/1877</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR: Months <i>7</i> Days <i>29</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Spring Grove St. Hosp. Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterioscler. Cardio vasc. Disease</i> DUE TO <i>Arteriosclerosis general, severe</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis general, severe</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 15, 1953</i> , to <i>9/29</i> , 1956, that I last saw the deceased alive on <i>9/29</i> , 1956, and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stella Wachslar</i> M.D.		ADDRESS (Street, city or town, state) <i>Spring Grove State Hospital</i> DATE SIGNED <i>9/29/56</i>	
PHYSICIAN'S NAME (Type) <i>STELLA WACHSLER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-2-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chamber</i> ADDRESS <i>517 11</i>		24a. REC'D BY REGISTRAR <i>W. E. Chamber</i> DATE <i>10/4 1956</i>	24b. REGISTRAR'S SIGNATURE <i>W. E. Chamber</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH	
6. PLACE OF BIRTH		7. OCCUPATION		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF OF BUREAU		18. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		19. SIGNATURE OF DEPUTY CHIEF OF BUREAU		20. SIGNATURE OF SECRETARY	

BUREAU V. S.

OCT 4 1906

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9139

CERTIFICATE OF DEATH

0912838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie Rd.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 529 Anneslie Rd.				d. STREET ADDRESS 529 Anneslie Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JENNIE Middle E. Last PARKER				4. DATE OF DEATH Month Sept. Day 24 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1897		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rev. Thomas S. Long				14. MOTHER'S MAIDEN NAME Mary May Trout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Frederick F. Parker-529 Anneslie Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17, 1956 to Sept. 24, 1956 , that I last saw the deceased alive on Sept. 24, 1956 , and that death occurred at 7:32 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Loy M. Zimmerman M.D.				ADDRESS (Street, city or town, state) 3202 Hartford Rd.		DATE SIGNED 9/24/56	
PHYSICIAN'S NAME (Type) Loy M. Zimmerman				Baltimore-18, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
DATE OF BURIAL		NAME OF BURIAL PLACE	
NAME OF MINISTER		NAME OF CLERGYMAN	
NAME OF FUNERAL HOME		NAME OF CEMETERY	
NAME OF CITY		NAME OF COUNTY	
NAME OF STATE		NAME OF COUNTRY	
NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
DATE OF BURIAL		NAME OF BURIAL PLACE	
NAME OF MINISTER		NAME OF CLERGYMAN	
NAME OF FUNERAL HOME		NAME OF CEMETERY	
NAME OF CITY		NAME OF COUNTY	
NAME OF STATE		NAME OF COUNTRY	

BUREAU V. S.

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9140

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena 02X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5660 Calyn Rd.		d. STREET ADDRESS Bayside Beach	
3. NAME OF DECEASED (Type or print) First SAVERIO Middle PARRINELLO Last		4. DATE OF DEATH Month Sept. Day 30 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Parrinello		14. MOTHER'S MAIDEN NAME Rose - (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) World War No 1		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Rose K. Parrinello-5660 Calyn Rd. #28		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of lung DUE TO (c) 3 mos.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/16 to 9/30 , 19 56 that I last saw the deceased alive on 9/30 , 19 56 , and that death occurred at 7:45 P. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 11 E. Chase, Balto, Md. DATE SIGNED	
ACTUAL SIGNATURE Christian S. Mass M.D.		DATE SIGNED Oct 3, 1956	
PHYSICIAN'S NAME (Type) Christian S. Mass			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS		ADDRESS Balto. 17, Md.	
24a. REC'D BY REGISTRAR Oct 3, 1956		24b. REGISTRAR'S SIGNATURE T. E. Lamm	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF REGISTRAR	
ADDRESS OF PHYSICIAN		ADDRESS OF REGISTRAR	
CITY OF PHYSICIAN		CITY OF REGISTRAR	
STATE OF PHYSICIAN		STATE OF REGISTRAR	
COUNTRY OF PHYSICIAN		COUNTRY OF REGISTRAR	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF REGISTRAR	
ADDRESS OF PHYSICIAN		ADDRESS OF REGISTRAR	
CITY OF PHYSICIAN		CITY OF REGISTRAR	
STATE OF PHYSICIAN		STATE OF REGISTRAR	
COUNTRY OF PHYSICIAN		COUNTRY OF REGISTRAR	

BUREAU V. 3

OCT 4 1956

RECEIVED

FOIA b7C
b7D
EX-100
OCT 10 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9141

CERTIFICATE OF DEATH

091304

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER J. PLOWMAN</u>				4. DATE OF DEATH Month Day Year <u>September 18 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 10, 1910</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Elmer Plowman</u>				14. MOTHER'S MAIDEN NAME <u>Anna (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CEREBRAL HEMORRHAGE WITH INTERVENTRICULAR RUPTURE</u> Due to: <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UNKNOWN</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 15</u> , 19 <u>56</u> , to <u>Sept. 18</u> , 19 <u>56</u> , that he was alive on <u>Sept. 15</u> , and that death occurred at <u>10:00AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald D. Mark</u>		ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Maryland</u>				DATE SIGNED <u>9-18-56</u>	
PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u>		ADDRESS <u>VAH FT. HOWARD, MD</u>				DATE <u>9-18-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Funeral Home</u>		ADDRESS <u>7401 Belair Rd. Balto. Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Newton L. Garber</u>	

CERTIFICATE OF DEATH

File No.

<p>1. Name of Deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Date of Birth: _____</p>	
<p>4. Place of Birth: _____</p>		<p>5. Race: _____</p>		<p>6. Occupation: _____</p>	
<p>7. Usual Residence: _____</p>		<p>8. Date of Death: _____</p>		<p>9. Time of Death: _____</p>	
<p>10. Cause of Death: _____</p>		<p>11. Immediate Cause: _____</p>		<p>12. Underlying Cause: _____</p>	
<p>13. Manner of Death: _____</p>		<p>14. Signature of Physician: _____</p>		<p>15. Signature of Registrar: _____</p>	
<p>16. Date of Report: _____</p>		<p>17. Name of Reporting Agency: _____</p>		<p>18. Name of Reporting Person: _____</p>	

BUREAU V. 5

SEP 20 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY <u>Balto</u> 9142 MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Balto</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>			c. LENGTH OF STAY IN 1b <u>30 yrs</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>24 N. Prospect Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>SELMA</u> First <u>POOLE</u> Middle Last			4. DATE OF DEATH <u>9/29/56</u> Month Day Year		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/97</u>		9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
13. FATHER'S NAME <u>Chas. Schwartzenbach</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Himmeler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			17. INFORMANT <u>Daughter</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Coronary sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u> <u>1 year</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)			(County) (State)		
21. I certify that I attended the deceased from <u>Dec 15, 1955</u> to <u>Sept 29, 1956</u> , that I last saw the deceased alive on <u>5-30</u> 19 <u>56</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Stephen Lee Magnus</u> M.D.			ADDRESS (Street, city or town, state) <u>908 Frederick St, Catonsville</u>		
PHYSICIAN'S NAME (Type) <u>STEPHEN LEE MAGNESS</u>			DATE SIGNED <u>10-1-56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>10/2/56</u>		<u>Western</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eric Hatt + Son</u> ADDRESS <u>28</u>			24a. REC'D BY REGISTRAR <u>DATE 10-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>T.E. Harry</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		U.S.A.		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SPOUSE		PARENTS	
SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		ONE		LIVING		LIVING	
PHYSICIAN'S SIGNATURE		PHYSICIAN'S NAME		PHYSICIAN'S ADDRESS		PHYSICIAN'S CITY		PHYSICIAN'S STATE		PHYSICIAN'S COUNTRY		PHYSICIAN'S PHONE		PHYSICIAN'S FAX		PHYSICIAN'S TELETYPE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. 8

OCT 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9143

CERTIFICATE OF DEATH

09132

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUDBURY ESSEX				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYDE PARK (21)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 E. GALENA RD				d. STREET ADDRESS 2 E. GALENA RD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Philip G. POPE				4. DATE OF DEATH Month Day Year SEPT. 25 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1890	
9. AGE (In years last birthday) 66 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) PITTSFIELD, MASS		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY BUILDING			
13. FATHER'S NAME Philip G. POPE				14. MOTHER'S MAIDEN NAME MARY MCKEWEEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address KATHERINE POPE 2 E. GALENA RD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Transitional cell Carcinoma - site undetermined. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-2-56 , 19 56 , to 9-25- , 19 56 , that I last saw the deceased alive on 9-25 , 19 56 , and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town state) 815 E.pton Ave Baltimore 21, 21 DATE SIGNED							
ACTUAL SIGNATURE Wm. A. Rodgers M.D.							
PHYSICIAN'S NAME (Type) William A. Rodgers, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/29/56		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran ADDRESS 2000 E. BALTO ST BALTO. MD				24a. REC'D BY REGISTRAR SEP 28 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is mostly blank with some faint markings.

BUREAU V. S.

SEP 28 1956

RECEIVED

Vertical text on the right edge of the page, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9144

CERTIFICATE OF DEATH

09133

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>		c. LENGTH OF STAY IN 1b <u>139 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>R</u> Last <u>PRICE</u>		4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 31, 1895</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Price</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Barrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <input checked="" type="checkbox"/> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>219 05 0821</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. n.</u> Month <u>VA</u> Day <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 8, 1956</u> , to <u>September 24, 1956</u> , that I last saw the deceased alive on <u>September 19, 1956</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Abraham A. Polacheke</u> M.D. <u>VAH, Fort Howard, Maryland</u> PHYSICIAN'S NAME (Type) <u>ABRAHAM A. POLACHEK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Texas, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN A. MORAN FUNERAL HOME</u> <u>per Mary M. Moran</u>		24a. REC'D BY REGISTRAR <u>SEP 26 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>			

9145

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 2 months				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PROVENZA Mary				4. DATE OF DEATH Month 9 Day 2 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/14/56	
9. AGE (In years last birthday) 2 1/2 mos.		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 56		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Edward Thomas Provenza				14. MOTHER'S MAIDEN NAME Marlene TROW Provenza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Parents			
17. INFORMANT Parents				Address 1315 S. Carey St., Balto., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus & spina bifida DUE TO (c) Congenital anomaly. INTERVAL BETWEEN ONSET AND DEATH July 7th 56							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 30th , 19 56 , to Sept. 2nd , 19 56 that I last saw the deceased alive on Sept. 1st , 19 56 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 9/2/56							
ACTUAL SIGNATURE Ernest I. Decko, M.D.				M.D. Rosewood State Training School			
PHYSICIAN'S NAME (Type) Ernest I. Decko				ADDRESS Owings Mills, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3/56		22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Washington Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schweinsberg Funeral Service				ADDRESS 1126 W. Cross St. Balto.			
24a. REC'D BY REGISTRAR Mary Blum				24b. REGISTRAR'S SIGNATURE Mary Blum			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF BIRTH [Faint text]</p>		<p>6. PLACE OF BIRTH [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. 2

SEP 4 1956

RECEIVED

9146

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>82 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>D.</u> Last <u>PURDUM</u>				4. DATE OF DEATH Month <u>September</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/76</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		11. BIRTHPLACE (State or foreign country) <u>Fountain Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William H. Purdum</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>SAW</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>POSTOPERATIVE INTESTINAL HEMORRHAGE</u> <u>153X</u> DUE TO <u>ADENOCARCINOMA OF COLON</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> (c) <u>UNKNOWN</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Small Pulmonary Infarcts.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>VA</u> <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>56</u> , to <u>Sept. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 30</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur G. Edwards</u> M.D.				ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, M.D.</u>		DATE SIGNED <u>9/30/56</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR G. EDWARDS, M.D.</u>				VAH, Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Knight - Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>OCT 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Parker</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CC

BUREAU V. 1

OCT 4 1956

RECEIVED

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. R.

SEP 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9148

CERTIFICATE OF DEATH

09137

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>2 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A.</u> Last <u>REGAN</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1918</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Work Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Joseph Regan</u>				14. MOTHER'S MAIDEN NAME <u>Annetta Rogers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>217-03-4248</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE FROM ESOPHAGEAL VARICES</u> <u>581.0</u> DUE TO <u>CIRRHOSIS OF LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Edema.</u> <u>Craniotomy with decompression for cerebral edema 9/27/56</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <u>VA</u> attended the deceased from <u>September 25, 1956</u> to <u>September 27, 1956</u> , that he was the decedent's <u>physician</u> , and that death occurred at <u>8:01 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Irving Freeman</u> M.D. <u>VETERANS ADMINISTRATION HOSPITAL 9/28/56</u>							
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D.</u> <u>FORT HOWARD, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran-3000 E. Baltimore St.</u> <u>per Mary M. Moran Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 1 1956

RECEIVED

9149

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1918 East Joppa Road</u>				d. STREET ADDRESS <u>1918 E. Joppa Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Elizabeth Roberts</u>				4. DATE OF DEATH <u>September 24 19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/26/1898</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ira Eugene Pyle</u>				14. MOTHER'S MAIDEN NAME <u>Ida Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Elmer C. Roberts</u> Address <u>1918 E. Joppa Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension - Arteriosclerotic C.V. Disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260x</u> (b) <u>Chr. Nephritis Diabetes Mellitus,</u> DUE TO (c) <u>Post Cerebral Hemorrhage,</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 10, 19 56</u> , to <u>9/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/24</u> , 19 <u>56</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathan Janney</u> M.D. <u>7101 Harford Rd.</u>				DATE SIGNED <u>9/25/56</u>			
PHYSICIAN'S NAME (Type) <u>Nathan Janney</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>SEP 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Brown</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-54

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09139

9150

CERTIFICATE OF DEATH

Reg. Dist. No. 33-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Balto</i>
CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural-White Hall</i>	LENGTH OF STAY (in this place) <i>4 yrs</i>	CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural-White Hall</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Old York Rd</i>		STREET ADDRESS (if rural give location) <i>Old York Rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Clyde Russell Rowland</i>		4. DATE OF DEATH <i>Sept 23 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>6 February 1904</i>
		9. AGE last birthday <i>52</i> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>anchorman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>selling</i>	11. BIRTHPLACE (State or foreign country) <i>Johnstown, Penna.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i> (If Yes, give war or dates of service) <i>1920-1924</i>		16. SOCIAL SECURITY NO. <i>159-16-0320</i>	
		17. INFORMANT & ADDRESS <i>wife- Mildred- same address</i>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>1 yr</i>	
IMMEDIATE CAUSE (A) <i>Cancer of Bowel</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>primary site undetermined</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)	21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 1953</i> , to <i>Sept 1956</i> , that I last saw the deceased alive on <i>21 Sept 56</i> , and that death occurred at <i>10 A</i> .M, from the causes and on the date stated above.			
SIGNATURE <i>Walter T. Kees</i>		DATE SIGNED <i>Cockeysville Md 23 Sept 56</i>	
M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>9/26/56</i>	NAME OF CEMETERY OR CREMATORY <i>West Liberty Cem.</i>	LOCATION (City, town, or county) (State) <i>White Hall, Md.</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>Robert L. Tucker</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Isaac Horstenstein</i>	
DATE <i>9/26/56</i>		ADDRESS <i>New Freedom, Pa.</i>	

DEED CERTIFICATE OF DEATH

SEP. 1956 No. 202

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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BUREAU V. S.

OCT 1 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09140
Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) York Rd.				d. STREET ADDRESS York Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John A. Howard Sauble				4. DATE OF DEATH Month September Day 15 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-1907		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pa inter		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sauble				14. MOTHER'S MAIDEN NAME Lillie Cofiell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War I 216-09-8896		17. INFORMANT Address Roger N. Sauble Reisterstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-56		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Reisterstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS Sparks, Maryland		24a. REC'D BY REGISTRAR 20 Sep 56 DATE	
				24b. REGISTRAR'S SIGNATURE Anna Annis MacPae			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09141

9152

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 40 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		d. STREET ADDRESS Kemp Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kemp Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha L. Schaefer		4. DATE OF DEATH Month Sept. Day 20 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1875
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Henry Long		14. MOTHER'S MAIDEN NAME Martha Straumm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 217-36-4089B	
17. INFORMANT Henry A. Schaefer, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X INTERVAL BETWEEN ONSET AND DEATH 3 days few yrs few yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-40 to 9-20-56 , that I last saw the deceased alive on 9-20-56 , and that death occurred at 10 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown, Md. DATE SIGNED 9-22-56 ACTUAL SIGNATURE James G. Saffell M.D. Reisterstown, Md. PHYSICIAN'S NAME (Type) James G. Saffell Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 25, 1956	
22c. NAME OF CEMETERY OR CREMATORY All-Saints		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 9-22-56	
24b. REGISTRAR'S SIGNATURE Mary B. Eline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG204 9-20-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

0914245

9153

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		d. STREET ADDRESS 600 Ross Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lee Benjamin Schafer		4. DATE OF DEATH Month 9 Day 12 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7th, 1888
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Retired		10b. KIND OF BUSINESS OR INDUSTRY Eastern Stainless	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Schafer		14. MOTHER'S MAIDEN NAME Clara Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Marie Schafer (Wife)		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1952 to 9/12, 1956 , that I last saw the deceased alive on 9/11/56 , and that death occurred at 12:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 423 Eastern Ave	
PHYSICIAN'S NAME (Type) Joseph Miceli		DATE SIGNED 9/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 14, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly, Essex, Md.		24a. REC'D BY REGISTRAR SEP 17 1956	
ADDRESS Essex, Md.		24b. REGISTRAR'S SIGNATURE Edith Hurley	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		38		Jan 1, 1918	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. St.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
Sep 17, 1956		Home		1000 N. E. St.		J. H. Harris	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF DEATH		STATE OF DEATH	
Sep 17, 1956		Home		Baltimore		Maryland	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY OF REGISTRATION		STATE OF REGISTRATION	
Sep 17, 1956		Home		Baltimore		Maryland	

RECEIVED
SEP 17 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9154

CERTIFICATE OF DEATH

09143

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3304 Garnet Road				d. STREET ADDRESS 3304 Garnet Road			
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE SCHLESINGER				4. DATE OF DEATH Month Day Year Sept. 12, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1869		9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Bach				14. MOTHER'S MAIDEN NAME Don't know			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna Rader 3304 Garnet Road 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Smility (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 1, 1956 , to Sept 12, 1956 , that I last saw the deceased alive on Sept 12, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. A. Grott M.D.				ADDRESS (Street, city or town, state) 8100 Harford Rd			
PHYSICIAN'S NAME (Type) H. A. GOTT, M.D.				DATE SIGNED 9/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Park		22d. LOCATION (City, town, or county) (State) Parkville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE SEP 17 1956		24b. REGISTRAR'S SIGNATURE Dr. A. M. R. R. R.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09144

9155

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>18yr5mt2ldys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Schlimmer</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1878</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Carl Schlimmer</u>		14. MOTHER'S MAIDEN NAME <u>Julia Arman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>4443X</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1953</u> to <u>Sept. 26, 1956</u> that I last saw the deceased alive on <u>Sept. 26, 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslor</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 9-27-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslor, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Old Frederick Rd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo J. Sweeney</u>		ADDRESS <u>1956</u>	
24a. REC'D BY REGISTRAR <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9156

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3701.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				d. STREET ADDRESS <u>533 Patapsco Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>SCHMIDT</u> Last				4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1862</u>		9. AGE (In years last birthday) yrs. <u>94</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Shop Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss Augusta Murr 533 Patapsco Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cowdry Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>Sept 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Cliff Ratliff Sr.</u> M.D. <u>4605 Edmonson Ave</u> 7/29/56 PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF SR.</u> <u>4605 EDMONDSON AVE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. A. A. Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Force</u>				ADDRESS <u>4001 Ritchie Hwy. (28)</u>		24a. REC'D BY REGISTRAR DATE <u>1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>T. E. Harvey</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9158

BUREAU V. S.

OCT 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09146

CERTIFICATE OF DEATH

Reg. Dist. No.

9157

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 417 S. ROBINSON STREET			
3. NAME OF DECEASED (Type or print) First ALBERT Middle J. Last SCHULTZ				4. DATE OF DEATH Month SEPTEMBER Day 12, Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-08	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY SCHULTZ				14. MOTHER'S MAIDEN NAME MARY STASKOWIAK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 214-03-4178		17. INFORMANT CLIN. REC., VET. ADM. HOSP, FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARDIOMEGALY; SCHIZOPHRENIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 27, 19 56</u> , to <u>SEPT. 12, 19 56</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above. live on <u>12-12-1956</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 9-12-56 ACTUAL SIGNATURE <u>Arthur G. Edwards</u> M.D. ARTHUR G. EDWARDS M.D. VAH, Fort Howard, Maryland 9-12-56 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/17/56		22c. NAME OF CEMETERY OR CREMATORY St. STANISLAUS CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE M.F. SADOWSKI & SONS, 1808 EASTERN AVE., BALTO. MD.				24a. REC'D BY REGISTRAR SEP 17 1956		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARTIN, JAMES		2. SEX Male		3. AGE 25 Years		4. DATE OF BIRTH 1934-03-17		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Student		7. MARITAL STATUS Single		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural		10. PLACE OF DEATH Home	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	
16. DATE OF DEATH 1956-09-17		17. TIME OF DEATH 10:00 AM		18. PLACE OF DEATH Home		19. NAME OF PHYSICIAN DR. J. H. SMITH		20. NAME OF REGISTRAR J. H. SMITH	
21. NAME OF CLERK J. H. SMITH		22. NAME OF PHYSICIAN DR. J. H. SMITH		23. NAME OF REGISTRAR J. H. SMITH		24. NAME OF CLERK J. H. SMITH		25. NAME OF PHYSICIAN DR. J. H. SMITH	

BUREAU V. 8

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09147

Reg. Dist. No.

30

9158

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville, Md.				c. LENGTH OF STAY IN 1b 19yr2mth23days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland			
f. STREET ADDRESS Baltimore City Hospital				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Scullion Last Scullion				4. DATE OF DEATH Month Sept. Day 18, Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown		9. AGE (In years last birthday) yrs. 76?		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joe Poussons				14. MOTHER'S MAIDEN NAME Mary Walters			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 19 53 to Sept. 18, 19 56 that I last saw the deceased alive on Sept. 18, 19 56 , and that death occurred at 1:35a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Stella Wachslar M.D.				SPRING GROVE STATE HOSPITAL 9-18-56			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/56		22c. NAME OF CEMETERY OR CREMATORY Euthelral		22d. LOCATION (City, town, or county) (State) old Frederick Rd	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Zahary				ADDRESS John J. Zahary		24a. REC'D BY REGISTRAR DATE SEP 20	
						24b. REGISTRAR'S SIGNATURE V. E. Barry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09148

Item 8 FilmG204 9-25-56 et

9039

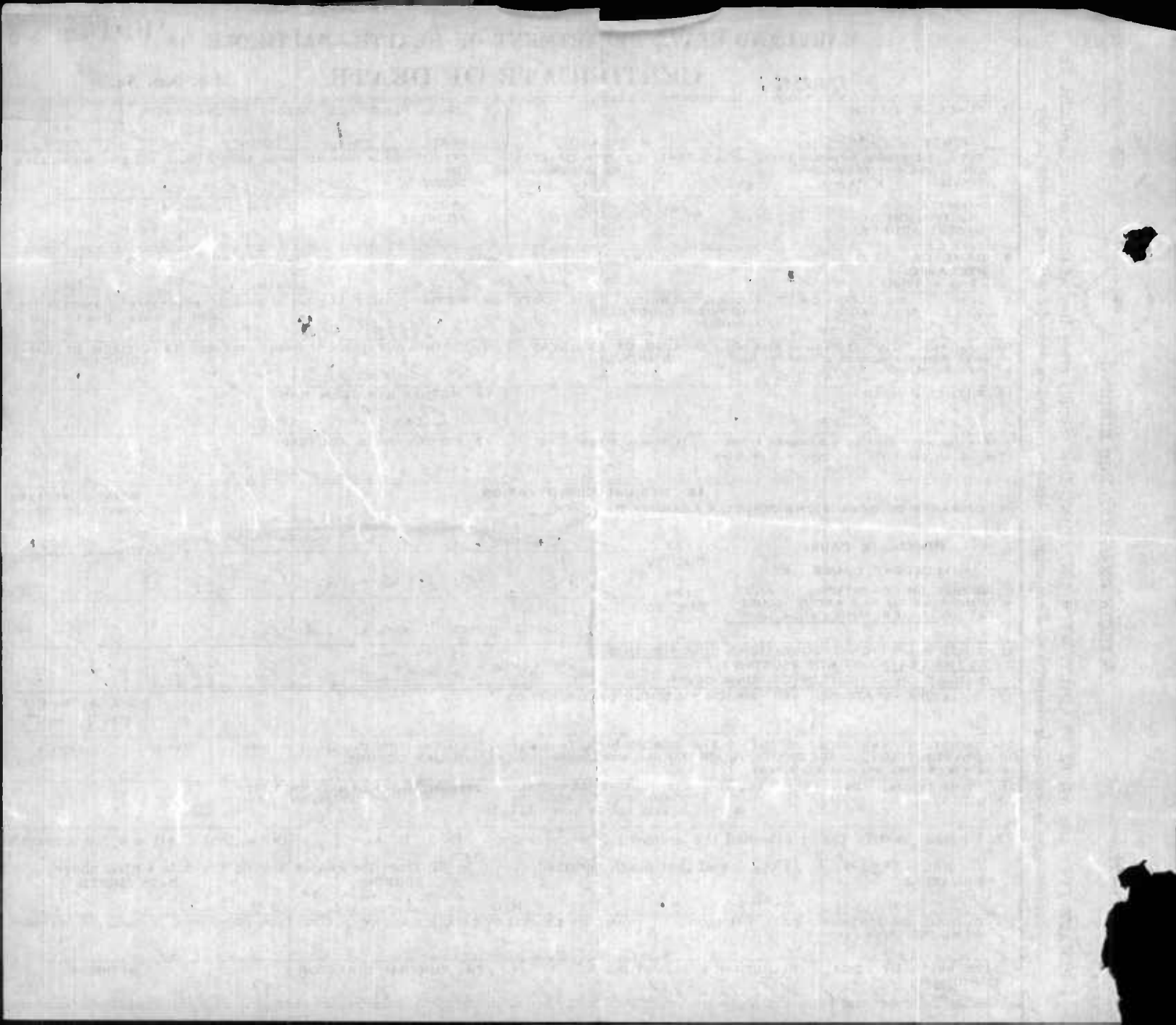
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>57</u> TOWN <u>Arbutus</u>		LENGTH OF STAY (in this place) <u>8 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>57</u> OR TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1223 North Ave</u>				STREET ADDRESS (If rural give location) <u>1223 North Ave</u>			
3. NAME OF DECEASED: (First) <u>Anna</u> (Middle) <u>Sebastian</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept 9 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Austria Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Nicholas Ross</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Catherine Wade Arbutus 22 md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Coronary occlusion</u>						4 hrs	
ANTECEDENT CAUSE (B) <u>chr Myocarditis</u>						1 1/2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>General Arterio</u>						5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>						4 yrs	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 1955, to <u>Sept 9</u> , 1956, that I last saw the deceased alive on <u>Sept 9</u> , 1956, and that death occurred at <u>2:35</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>B. B. Brumbaugh</u>		ADDRESS <u>5609 Main St</u>		DATE SIGNED <u>9/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Frederick Ave</u>		LOCATION (City, town, or county) (State) <u>md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept 10, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Frederick Ave</u>		ADDRESS <u>5646 Carroll Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09149

9159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chartley Farms</u>				d. STREET ADDRESS <u>Chartley Farms</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Whitney Shirley, Jr.</u>				4. DATE OF DEATH Month Day Year <u>Sept. 5 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 7, 1905</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Whitney Shirley, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Davidson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Eliz. M. Math Shirley, Chartley Farms</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glyndon, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Mowen Co., 108 W. North Ave., Balto.-1-Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

MEDICAL CERTIFICATION

2

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and file, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ME(S)
SS

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hhd. Co. Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>25 years 4m.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Slade</u> Middle <u>Slade</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-94</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Salde</u>	
14. MOTHER'S MAIDEN NAME <u>Rose Wheeler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>904.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia - Possible tuberculosis - Fractured left hip</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. pushed down by another pt. on 7-25-56 with resulting fractured left hip.</u>		20c. TIME OF INJURY Month, Day, Year <u>7-25, 19 56</u> Hour <u> </u> a. m. <u> </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u> </u> of work <u> </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Catonsville 28, Md.</u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Sept. 27, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	22d. LOCATION (City, town, or county) (State) <u>Old Frederick Rd</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. J. T. ...</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>1956</u>			

MEDICAL CERTIFICATION

03

2

5

SS

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

W. VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten information.

BUREAU V. S.

OCT 1 1956

RECEIVED

9161

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore City MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 848 W. 36th St.			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Francis Smart				4. DATE OF DEATH Month Day Year September 16 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY OIL Co		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Thomas Smart				14. MOTHER'S MAIDEN NAME Helen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 714-209598		17. INFORMANT Maude Smart (wife)		848 W. 36th St. Baltimore 11, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4-21-56 , 19 56 , to September 16, 19 56 , that I last saw the deceased alive on September 16, 19 56 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles Ward</i>				ADDRESS (Street, city or town, state) Spring Grove State Hospital			
PHYSICIAN'S NAME (Type) Charles Ward				DATE SIGNED Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept 19-1956		22c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL CEM		22d. LOCATION (City, town, or county) (State) BALTO Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. B. M. Walters</i>				24a. REC'D BY REGISTRAR 18 1956		24b. REGISTRAR'S SIGNATURE <i>V. E. Hays</i>	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 by the hospital or attending physician.
 DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1956		10:00 AM		Home		Natural		Dr. Smith		J. Doe		Mrs. Doe	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Outpatient Visit		Last Prescription		Last X-ray		Last Blood Test		Last Urine Test	
Teacher		Married		High School		Catholic		White		White		Hypertension		1955		1955		1955		1955		1955		1955		1955	
Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
1956		10:00 AM		Home		Natural		Dr. Smith		J. Doe		Mrs. Doe		1956		10:00 AM		Home		Natural		Dr. Smith		J. Doe		Mrs. Doe	

BUREAU V. S.

SEP 13 1956

RECEIVED

9162

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex, Rockaway Beach</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Beach Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>765 G Greyhound Rd.</u>				d. STREET ADDRESS <u>Box 154 Cedar Beach</u>			
3. NAME OF DECEASED (Type or print) First <u>Elvena</u> Middle <u>Snyder</u> Last				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Weiss</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-4167</u>		17. INFORMANT <u>Lillian Mai 675 G Greyhound Rd. Balto. 21, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>14 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Permeious Anaemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/29/56</u> to <u>9/13/56</u> , that I last saw the deceased alive on <u>9/4/56</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>423 Eastern</u> DATE SIGNED <u>9/14/56</u> ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D. Essex 21, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mathew's</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Christine Brudzinski</u>				24a. REC'D BY REGISTRAR DATE <u>9/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MEDICAL CERTIFICATION

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 and by the hospital or attending physician.
 DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09153

Reg. Dist. No. **45**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00				d. STREET ADDRESS 956 N. Marlyn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna First Mary Middle Staab Last				4. DATE OF DEATH Month Sept Day 2 Year 19 56					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 25, 1908			
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Wagner				14. MOTHER'S MAIDEN NAME Tina Stepek					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT John T. Staab		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 416X IMMEDIATE CAUSE (a) Rheumatic Heart Dis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 30 yrs		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Jack Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 9-8-56	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-6-1956		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				ADDRESS Essex, Md.		24a. REC'D BY REGISTRAR DATE SEP 6 1956		24b. REGISTRAR'S SIGNATURE Edith Hanley	

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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STATE AND STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS' CERTIFICATE OF DEATH

BUREAU Y. B.

SEP 6 1956

RECEIVED

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
RECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09154

Reg. Dist. No.

4v

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balti.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4806 Leeds Ave		d. STREET ADDRESS 4806 Leeds Ave	
3. NAME OF DECEASED (Type or print) George First J. Middle STROMER Last		4. DATE OF DEATH Month 9 Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE Wk	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10b. KIND OF BUSINESS OR INDUSTRY Ice Company	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John STROMER		14. MOTHER'S MAIDEN NAME LASNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-01-6540	
17. INFORMANT MISS MARGAROT STROMER Address 4806 Leeds			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 4 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/10/53 , 19 53 , to 9/5 , 19 56 , that I last saw the deceased alive on 9/5 , 19 56 , and that death occurred at 12 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Laukaitis M.D.		ADDRESS (Street, city or town, state) 679 Washington Blvd Baltimore 30md	
PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-7-1956	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) 4300 Old Federal Rd	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny ADDRESS 1600 Hollins St		24a. REC'D BY REGISTRAR Dr. M. J. Juffer	
24b. REGISTRAR'S SIGNATURE			

SEP 6 1956

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09155 30
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WILHE BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	c. LENGTH OF STAY IN 1b <u>5yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>627 Plymouth Rd</u>		d. STREET ADDRESS <u>627 Plymouth Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie Ray Stube</u>		4. DATE OF DEATH Month Day Year <u>Sept 9 19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brake Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bro RR</u>	9. AGE (In years last birthday) <u>65</u> yrs.
13. FATHER'S NAME <u>Daniel Stube</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Leherthy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dr. M. Kieffer</u>		DATE SIGNED <u>Sept 10 56</u>	
EXAMINER'S NAME (Type) <u>CLERK S. M. KIEFFER</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Buried Sept 17 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
22b. DATE THEREOF <u>Sept 17 1956</u>		22d. LOCATION (City, town, or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. Walters</u>		24a. REC'D BY REGISTRAR <u>SEP 11 1956</u>	
ADDRESS <u>Stuiter St</u>		24b. REGISTRAR'S SIGNATURE <u>F. E. Harry</u>	

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 11

9561 11 5

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9165 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09156

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EDWARDS BOAT YARD - BOWLEY'S QUARTERS</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>2932 N CALVERT ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS JOSEPH TERZI</u>				4. DATE OF DEATH Month Day Year <u>SEPT 23 1956</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 14 1909</u>		9. AGE (In years last birthday) <u>47</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOVEL OPT.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MATTRICINI CONT</u>				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOSEPH TERZI</u>				14. MOTHER'S MAIDEN NAME <u>MARY ZANELETTI</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <input checked="" type="checkbox"/> <u>WORLD WAR II</u>				16. SOCIAL SECURITY NO. <u>217-09-8886</u>				17. INFORMANT Address <u>MARY A TERZI 2932 N CALVERT ST</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING - ACCIDENT</u> <u>929.8</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unknown</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient entered water to aid wife and drowned self as a result</u>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>as above</u>		20f. (City or town) (County) (State) <u>as above</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Jack C. Collins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>2 Kinship Rd</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-23-56</u>					
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>SEPT 26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM</u>				22d. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>DIPPEL BROS. 1800 E LOMBARD ST</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Turley</u>			

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
FAMILY HISTORY		PRE-MORTEM EXAMINATION		LABORATORY EXAMINATIONS		TOXICOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATION		OTHER EXAMINATIONS	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION	

BUREAU V. S.

SEP 26 1956

RECEIVED

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with
Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, Film G203 9-11-56 et

CERTIFICATE OF DEATH

0915730

Reg. Dist. No.

9166

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr. George's Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
c. LENGTH OF STAY IN 1b <u>19 days.</u>		d. STREET ADDRESS <u>804 - 57th. Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Katherine</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>196</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-89</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Herman Radtke</u>		14. MOTHER'S MAIDEN NAME <u>Willamena Zinke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph C. Tarmon - 1139 Chaplin St. S.E.</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>200X</u> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetis.</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 17, 1956</u> , to <u>Sept. 5, 1956</u> , that I last saw the deceased alive on <u>Sept. 5, 1956</u> , and that death occurred at <u>7 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.		DATE SIGNED <u>Sept. 6, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Charles Ward, M.D. - Spring Grove State Hospital, Catonsville 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Church</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee Sons Co.</u>		24a. REC'D BY REGISTRAR <u>Wash., D.C.</u> DATE <u>10/1956</u>	
24b. REGISTRAR'S SIGNATURE <u>T. L. Barry</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

EP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9167

CERTIFICATE OF DEATH

Reg. Dist. No. 09158

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall Md</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall R.D.</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATTHEW</u> <u>—</u> <u>THORNTON</u>				4. DATE OF DEATH Month Day Year <u>SEPT</u> <u>26</u> <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>EO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>—</u> <u>1889</u> <u>67</u> yrs.	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Maggie Thornton</u>		Address <u>White Hall Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 25</u> , 19 <u>56</u> , to <u>Sept. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 25</u> , 19 <u>56</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				DATE SIGNED <u>Parkton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>Sept 29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Joy</u>		22d. LOCATION (City, town, or county) (State) <u>Troy Road Monkton Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Master E. Knitz</u>	
ADDRESS <u>Carrollville Md.</u>		24a. REC'D BY REGISTRAR <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Knott</u>		DATE	

MEDICAL CERTIFICATION

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 signed by the hospital or attending physician.
 DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09159

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>17 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>312 E. PENN. AVE</u>				d. STREET ADDRESS <u>312 E. PENN. AVE,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MANSON</u> Middle <u>L.</u> Last <u>TUCKER</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>3</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6, 1896</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PORTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>		11. BIRTH PLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Claramount, R. Tucker</u> <u>312 E. Penna. Ave. Towson, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>1 YR.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>9/3/56</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Sept. 7, 1956</u>		<u>Abraham Mem. Pk.</u>		<u>Baltimore Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1631 Grand Hill Ave</u>				24a. REC'D BY REGISTRAR <u>SEP 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute, in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 2 d

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INSTRUCTIONS

1. **INFORMING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09160

9169

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>COCKEYSVILLE</u> LENGTH OF STAY (in this place) <u>8 YRS.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MASONIC HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> 3V01-4 STREET ADDRESS (If rural give location) <u>701 CATHEDRAL ST</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CARRIE VIRGINIA TURLINGTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>9 2 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>8-12-1868</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS G. TITTLE</u>				14. MOTHER'S MAIDEN NAME <u>LAURA V. ALBAUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frank L. Smith, Jr., Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4221 IMMEDIATE CAUSE (A) <u>Arterio Sclerotic Cardis</u> ANTECEDENT CAUSE(S) DUE TO <u>Vascular disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						8 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 8/56</u> , 19 <u>56</u> , to <u>Aug 56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>56</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Walter J. Kees</u> ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Goodson PK</u>		LOCATION (City, town, or county) (State) <u>BAL to Md</u>	
24. REC'D BY REGISTRAR <u>SEP 4 1956</u>		REGISTRAR'S SIGNATURE <u>Frank Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc</u> ADDRESS <u>1217 St Paul St</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Reg. Civ. No.

1. USUAL RESIDENCE (WARD OR DISTRICT)

DECEASED

DATE OF DEATH

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. SIGNATURE OF DECEASED

6. SIGNATURE OF WITNESSES

BUREAU V. 3

SEP 5 1956

RECEIVED

SMITHSONIAN

9170

CERTIFICATE OF DEATH

Reg. Dist. No.

09161

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY IN 1b 2 yrs. 8 mo.		d. STREET ADDRESS 1001 W. Joppa Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers of the Sacred Heart, 1001 W. Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SISTER MARY CECILIA (WASHINGTON)		4. DATE OF DEATH Month SEPT. Day 7 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1890
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teaching Religion		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) New York, N. Y.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME George Washington		14. MOTHER'S MAIDEN NAME Mary Meehan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Rd. Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Renal DUE TO (c) Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1952 to Sept 6 , 19 56 that I last saw the deceased alive on September 5, 1956 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd Towson DATE SIGNED 9/7/56			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D. Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/56	
22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery,		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon		ADDRESS 4611 Park Heights Ave., Balto. Md.	
24a. REC'D BY REGISTRAR DATE SEP 10 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

BUREAU V. S.

SEP 10 1956

RECEIVED

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INSTRUCTIONS

1. The law requires that the death certificate be executed within 24 hours after death.

2. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09162

9171 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Fredrick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Towson</i>		LENGTH OF STAY (in this place) <i>3 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Fredrick</i>		<i>10x-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Stella Maria Hospice</i>				STREET ADDRESS (If rural give location) <i>Rt 2</i>			
3. NAME OF DECEASED (Type or Print) <i>AUGUSTA Meluzina Wasson</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>9-16-1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>12-25-81</i>	9. AGE last birthday <i>75 7/8</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <i>HOUSEWIFE</i>)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Philip Lawenson</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Beatty</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Philip Wasson, 1304 English Ave</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
442x IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						<i>22 hrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardia</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Renal Vascular Disease</i>						<i>10 yrs</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/8</i> , 19 <i>56</i> , to <i>9/15</i> , 19 <i>56</i> that I last saw the deceased alive on <i>9/15</i> , 19 <i>56</i> , and that death occurred at <i>7:15</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>John M. Crumell</i>				ADDRESS (Street, city, town, state) <i>7501 York Rd Towson, Md</i>		DATE SIGNED <i>9/15/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>9-18-56</i>		NAME OF CEMETERY OR CREMATORY <i>ST. CHARLES CHURCH CEM.</i>		LOCATION (City, town, or county) (State) <i>PITESVILLE MD</i>	
24. REC'D BY REGISTRAR DATE <i>Sept. 18, 1956</i>		REGISTRAR'S SIGNATURE <i>Mabel Gray</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>HW JENKINS & SONS Co.</i>		ADDRESS <i>4905 YORK RD</i>	

CERTIFICATE OF DEATH

State of Massachusetts

County of _____

City of _____

State of _____

County of _____

City of _____

State of _____

City of _____

State of _____

City of _____

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BUREAU V. 2

SEP 19 1956

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1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 9172 CERTIFICATE OF DEATH

09163

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>California</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>S. Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u> <u>1002 N. Rolling Rd.</u>				d. STREET ADDRESS <u>821 Adelain Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>KENNETH</u> Middle <u>CLAYTON</u> Last <u>WATSON</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1901</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Watson, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Clayton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-01-1102</u>		17. INFORMANT <u>Miss Katherine M. Watson-606 Cathedral St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis - (Alcohol)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pleurisy effusion</u> DUE TO (c) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>6 months</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1, 1956</u> , to <u>Sept. 18, 1956</u> , that I last saw the deceased alive on <u>Sept. 18, 1956</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wetherbee Fort</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1118 St. Paul - Baltimore 2, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons - Balto. 17, Md. (B.P.P.)</u>				24a. REC'D BY REGISTRAR <u>DATE 191956</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harty</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 15 1890		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1915		BALTIMORE, MD		JAN 15 1956		BALTIMORE, MD	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
LABORER		JAN 15 1915		BALTIMORE, MD		JAN 15 1956		BALTIMORE, MD	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 15 1956		BALTIMORE, MD		JAN 15 1956		BALTIMORE, MD	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 15 1956		BALTIMORE, MD		JAN 15 1956		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 15 1956		BALTIMORE, MD		JAN 15 1956		BALTIMORE, MD	

BUREAU V. 2

JAN 20 1956

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OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
d by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9173
CERTIFICATE OF DEATH

09164

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6001 Hazelwood Ave.		d. STREET ADDRESS 6001 Hazelwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katie O Weilbrenner		4. DATE OF DEATH Month Day Year Sept. 15, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Blizzard		14. MOTHER'S MAIDEN NAME Laura Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bradley Weilbrenner		Address 4610 Mary Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Interval BETWEEN ONSET AND DEATH Coronary Occlusion Hypertension Cardio-Vascular Renal Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 1956, to Sept 15, 1956, that I last saw the deceased alive on 9-14, 1956, and that death occurred at 7:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael J. Grossfeld M.D.		DATE SIGNED Sept 15, 1956	
PHYSICIAN'S NAME (Type) Michael J. Grossfeld M.D.		ADDRESS (Street, city or town, state) 5407 Belair Rd. Balto 6 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE SEP 20 1956		24b. REGISTRAR'S SIGNATURE Mrs. H. L. Reysneider	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
LAST NAME FIRST MIDDLE		MONTH DAY YEAR	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH	
CITY		COUNTY	
STATE		COUNTRY	
CAUSE OF DEATH		MANNER OF DEATH	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
DATE OF EXAMINATION		SIGNATURE OF PHYSICIAN	
DATE OF REPORT		SIGNATURE OF REGISTRAR	

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SEP 20 1956

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by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the information required by the law. The funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the information required by the law. The funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the information required by the law.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9174

CERTIFICATE OF DEATH

09165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 N.Symington Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles C. White				4. DATE OF DEATH Sept. 29 19 56			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1884	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocery				10b. KIND OF BUSINESS OR INDUSTRY Own	11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles P. White				14. MOTHER'S MAIDEN NAME Sarah Brimmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Mr. Preston White Address 103 N.Symington Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH one week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 54 to 9/19 19 56 , that I last saw the deceased alive on 9/23/56 , 19 56 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert W. Lapp M.D.				DATE SIGNED Oct 10/19 56			
PHYSICIAN'S NAME (Type) Herbert W. LAPP M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3/56	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke ADDRESS 4101 Edmondson Ave				24a. REC'D BY REGISTRAR OCT 2 1956		24b. REGISTRAR'S SIGNATURE F. E. Harry	

BUREAU V. S.

OCT 2 1956

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

46

9175

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Baltimore 20</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3600 Bengois Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CORDELIA</u> First <u>Wilson</u> Middle <u>Wilson</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec-25-1909</u>		9. AGE (In years last birthday) <u>46</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto-co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brody Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Leroy Wilson - same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>for M. B. DAVIS</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Melvin B. Davis</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharp St</u>		22d. LOCATION (City, town, or county) (State) <u>Chase md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O. Wilson</u>				ADDRESS <u>1000 Sontag</u>		24a. REC'D BY REGISTRAR <u>Edith Sharkey</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Sharkey</u>		DATE <u>Sept. 18, 1957</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

A34

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

SEP 19 1956

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NOT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ME(5)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9176 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09168

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>21 Calverton Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>Z</u> Middle <u>ZUKAS</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Unknown</u>	8. DATE OF BIRTH <u>March 6, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter ZUKAS</u>		14. MOTHER'S MAIDEN NAME <u>Cilekine Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ann Benedick</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>80 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>9-27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lichman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Amount addition St. Clair St. Balt., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James W. Dugan</u> ADDRESS <u>1407 Eastern Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>9/29/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESSES	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. PLACE OF DEATH		16. DATE OF DEATH		17. SIGNATURE OF EXAMINER		18. SIGNATURE OF WITNESSES	
19. PLACE OF BIRTH		20. DATE OF BIRTH		21. PLACE OF DEATH		22. DATE OF DEATH		23. SIGNATURE OF EXAMINER		24. SIGNATURE OF WITNESSES	
25. PLACE OF BIRTH		26. DATE OF BIRTH		27. PLACE OF DEATH		28. DATE OF DEATH		29. SIGNATURE OF EXAMINER		30. SIGNATURE OF WITNESSES	
31. PLACE OF BIRTH		32. DATE OF BIRTH		33. PLACE OF DEATH		34. DATE OF DEATH		35. SIGNATURE OF EXAMINER		36. SIGNATURE OF WITNESSES	
37. PLACE OF BIRTH		38. DATE OF BIRTH		39. PLACE OF DEATH		40. DATE OF DEATH		41. SIGNATURE OF EXAMINER		42. SIGNATURE OF WITNESSES	
43. PLACE OF BIRTH		44. DATE OF BIRTH		45. PLACE OF DEATH		46. DATE OF DEATH		47. SIGNATURE OF EXAMINER		48. SIGNATURE OF WITNESSES	
49. PLACE OF BIRTH		50. DATE OF BIRTH		51. PLACE OF DEATH		52. DATE OF DEATH		53. SIGNATURE OF EXAMINER		54. SIGNATURE OF WITNESSES	
55. PLACE OF BIRTH		56. DATE OF BIRTH		57. PLACE OF DEATH		58. DATE OF DEATH		59. SIGNATURE OF EXAMINER		60. SIGNATURE OF WITNESSES	
61. PLACE OF BIRTH		62. DATE OF BIRTH		63. PLACE OF DEATH		64. DATE OF DEATH		65. SIGNATURE OF EXAMINER		66. SIGNATURE OF WITNESSES	
67. PLACE OF BIRTH		68. DATE OF BIRTH		69. PLACE OF DEATH		70. DATE OF DEATH		71. SIGNATURE OF EXAMINER		72. SIGNATURE OF WITNESSES	
73. PLACE OF BIRTH		74. DATE OF BIRTH		75. PLACE OF DEATH		76. DATE OF DEATH		77. SIGNATURE OF EXAMINER		78. SIGNATURE OF WITNESSES	
79. PLACE OF BIRTH		80. DATE OF BIRTH		81. PLACE OF DEATH		82. DATE OF DEATH		83. SIGNATURE OF EXAMINER		84. SIGNATURE OF WITNESSES	
85. PLACE OF BIRTH		86. DATE OF BIRTH		87. PLACE OF DEATH		88. DATE OF DEATH		89. SIGNATURE OF EXAMINER		90. SIGNATURE OF WITNESSES	
91. PLACE OF BIRTH		92. DATE OF BIRTH		93. PLACE OF DEATH		94. DATE OF DEATH		95. SIGNATURE OF EXAMINER		96. SIGNATURE OF WITNESSES	
97. PLACE OF BIRTH		98. DATE OF BIRTH		99. PLACE OF DEATH		100. DATE OF DEATH		101. SIGNATURE OF EXAMINER		102. SIGNATURE OF WITNESSES	

BUREAU V. S.

OCT 2 1956

RECEIVED